

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00804

850

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shawnee-Croft Foundation</u>		d. STREET ADDRESS <u>Route 1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henrietta</u> Middle <u>META</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 22 - 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Bremen, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Morris Richter</u>		14. MOTHER'S MAIDEN NAME <u>Adella Cordia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>J. A. Thompson</u>		Address <u>341 St. Georges Rd. N.W. Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> 422.1 DUE TO (b) <u>Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/14</u> to <u>1/14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/14</u> , 19 <u>58</u> , and that death occurred at <u>3:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. W. Bird</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Sandy Spring</u> <u>1/14/58</u>	
PHYSICIAN'S NAME (Type) <u>J. W. BIRD, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/16/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sank's Sons</u>		24a. REC'D BY REGISTRAR <u>1756 Pennsylvania Ave NW, Washington, DC</u>	
24b. REGISTRAR'S SIGNATURE <u>Jan 14 1958</u>			

BUREAU V. S.

JAN 16 1953

RECEIVED

CERTIFICATE OF DEATH

00805

Reg. Dist. No.

851

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 210 E. Melbourne	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Emma Streng Ager		4. DATE OF DEATH Month Jan. Day 26 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gustave Streng		14. MOTHER'S MAIDEN NAME Caroline Laupp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Thelma Ager		Address 210 E. Melbourne St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, abdominal 451x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Aneurysm, aorta, (ruptured)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 10 yrs 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1955 , to Jan 26, 1958 , that I last saw the deceased alive on Jan 26, 1958 , and that death occurred at 7:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED A. W. Smith M.D. 4601 16th St NW 1/27/58 ACTUAL SIGNATURE A. W. SMITH Wash. D. C. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-29-58	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		ADDRESS 4812 Ga. Ave. N. W. Wash. D. C.	
24a. REC'D BY REGISTRAR DEC 3 '58		24b. REGISTRAR'S SIGNATURE Deal	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

852

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Minnesota b. COUNTY Red Wing			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 Mo. 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 411 8th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First August Middle Herman Last ANDRESEN				4. DATE OF DEATH Month January Day 14 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 October 1890		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Congressman		10b. KIND OF BUSINESS OR INDUSTRY Politics		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Oley Andresen				14. MOTHER'S MAIDEN NAME Anna Lunke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Official Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Hypertensive Vascular disease				INTERVAL BETWEEN ONSET AND DEATH 48 days 3 years 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastrointestinal bleeding due to duodenal ulcer 11-27-57				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 1 December , 19 57 , to 14 January , 19 58 , that I last saw the deceased alive on 14 January , 19 58 , and that death occurred at 12:06 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thirl Jarrett				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-14-58			
PHYSICIAN'S NAME (Type) Thirl Jarrett, Capt, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-20-58		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Red Wing Minnesota	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph H. H. H. H. ADDRESS Gawler's, 1756 Penn Ave., Washington, D. C.				24a. REC'D BY REGISTRAR DATE JAN 17 '58		24b. REGISTRAR'S SIGNATURE W. H. H.	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

PAU V. S.

JAN 17 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

853

CERTIFICATE OF DEATH

00807

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Lane Nursing Home</u>				d. STREET ADDRESS <u>7902 Glenbrook Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>E.</u> Last <u>ANDREWS</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mch. 18, 1872</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Frederick C. Stang</u>				14. MOTHER'S MAIDEN NAME <u>Mosburg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>E.C. Andrews-Item# 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE HEART DISEASE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENSIBILITY</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>NOV. 2</u> , 19 <u>57</u> , to <u>JAN. 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JAN. 28</u> , 19 <u>58</u> , and that death occurred at <u>11:25 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>5206 Narva Rd</u> <u>1-28-58</u> ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D. <u>Cherry Chase, Md</u> PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	

CERTIFICATE OF DEATH

State of Maryland

DEPARTMENT OF HEALTH - BIRTH OR 13

BUREAU V. S.

JAN 30 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

854

CERTIFICATE OF DEATH

00808

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg			c. LENGTH OF STAY IN 1b 50 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 305 North Frederick Ave,				d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EVA First DUTROW Middle AYTON Last				4. DATE OF DEATH Jan. Month 25 Day 19 58 Year				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 26 1878		
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME Jacob Walter Dutrow				14. MOTHER'S MAIDEN NAME Jane Williams				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hersey D. Ayton		Address Same A² I		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary congestion DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X (b) Hypertensive & Arteriosclerotic HD DUE TO 18 yrs (c)							INTERVAL BETWEEN ONSET AND DEATH 10d	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, cerebral vascular accidents							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19 56 to Jan 25 19 58 that I last saw the deceased alive on Jan 25 19 58 , and that death occurred at 9:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 809 Viers Mill Rd. Rockville, Md. DATE SIGNED Jan 25, 19 58								
ACTUAL SIGNATURE G. Bowditch Hunter Jr.		M.D. 809 Viers Mill Rd. Rockville, Md.						
PHYSICIAN'S NAME (Type) G. Bowditch Hunter Jr.		Rockville, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 28 58		22c. NAME OF CEMETERY OR CREMATORY Forrest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber				ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE JAN 29 58		
				24b. REGISTRAR'S SIGNATURE W. Search				

MEDICAL CERTIFICATION

8361 62 JAN

RECEIVED

855

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Comus		c. LENGTH OF STAY IN 1b 15 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Comus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Ralph Middle Anderson Last Baldwin				4. DATE OF DEATH Month January Day 15 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9-1885		9. AGE (In years last birthday) 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper for landscape gardener		10b. KIND OF BUSINESS OR INDUSTRY Ohio		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME Harvey G. Baldwin			14. MOTHER'S MAIDEN NAME Emma Strawn		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-24-2701		17. INFORMANT Mrs Ruth Baldwin, Comus, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic Stenosis with congestive hrt fail. 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerosis DUE TO (c) 5 years					INTERVAL BETWEEN ONSET AND DEATH 2 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Degenerative disease of Dorsal Vertebrae					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 16 Dec., 1957 , to 15 Jan., 1958 , that I last saw the deceased alive on 14 Jan., 1958 , and that death occurred at 1:45 A.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE Gordon M. Smith		ADDRESS (Street, city or town, state) Barnesville, Md.		DATE SIGNED 15 Jan. 58	
PHYSICIAN'S NAME (Type) Gordon M. Smith, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/18/58		22c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Cemetery	
22d. LOCATION (City, town, or county) Frederick		(State) Md			
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton, Barnesville Md		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 17 '58	
24b. REGISTRAR'S SIGNATURE W. B. Hilton					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 17 1958

RECEIVED

809

CERTIFICATE OF DEATH

00810
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
c. LENGTH OF STAY IN 1b 1 week		d. STREET ADDRESS 2309 LINDEN LANE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 517 ALBANY AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MRS. SARA ANN BARBER		4. DATE OF DEATH Month JAN. Day 18 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/65
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN A. TURNER	
14. MOTHER'S MAIDEN NAME CATHERINE STUART		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mr. Gilbert W. Barber, Tompkinsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Forming acute seizure DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) He had an upper extremity infarct but not			INTERVAL BETWEEN ONSET AND DEATH 1 week
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 3 19 58 to Jan 18 19 58 , that I last saw the deceased alive on 1/17/58 19 58 , and that death occurred at 4:30 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Chas. H. W. Latham		ADDRESS (Street, city or town, state) 500 Underwood St. N.W. DATE SIGNED Washington D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/21/58	
22c. NAME OF CEMETERY OR CREMATORY COLESVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner S. Humphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JAN 23 '58 24b. REGISTRAR'S SIGNATURE Arthur Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
CITY [Faint text]		COUNTY [Faint text]	
STATE [Faint text]		ZIP CODE [Faint text]	

BUREAU V. S.

JAN 23 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

810

CERTIFICATE OF DEATH

00811

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 56		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>3813 Kelsey St.</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Babe Eileen Beckton</u>		4. DATE OF DEATH Month Day Year <u>January 6 1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 5 1958</u>	
9. AGE (In years last birthday) yrs. <u>8</u>		IF UNDER 1 YEAR Months Days Hours Min <u>56</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Charles Albert Beckton Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Milled Kneisley</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		
17. INFORMANT <u> </u>		Address <u> </u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1-5-</u> , 19 <u>58</u> , to <u>1-6-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-6-</u> , 19 <u>58</u> , and that death occurred at <u>2:45 P.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED				
ACTUAL SIGNATURE <u>Winston E. Cochran</u> M.D.				
PHYSICIAN'S NAME (Type) <u>Winston E. Cochran, M.D. 927 Pershing Dr., Silver Spring, Md.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1-7-58</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hospital, Takoma Park, Md.</u>		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Gann, M.D.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 9 '58</u>		
24b. REGISTRAR'S SIGNATURE <u> </u>				

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BUREAU V. S.

JAN 9 1958

RECEIVED

856

CERTIFICATE OF DEATH

00812

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp</u>				d. STREET ADDRESS <u>7107 45th St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAURA VIRGINIA BELT</u>				4. DATE OF DEATH Month Day Year <u>1 26 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-1875</u>		9. AGE (In years last birthday) <u>83</u> yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min. <u>0 18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas West</u>				14. MOTHER'S MAIDEN NAME <u>Caroline R. Shanks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>SON</u> Address <u>5103 JANUARY RD. BETH.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage of Rt Cerebral Artery</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>25 Jan, 1958</u> , to <u>26 Jan, 1958</u> , that I last saw the deceased alive on <u>26 Jan, 1958</u> , and that death occurred at <u>6:21 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Herbert Martyn Jr. M.D. 5029 Bethesda Ave. 26 Jan 58</u>							
ACTUAL SIGNATURE <u>HERBERT MARTYN JR</u>				PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/28/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert D. Humphrey</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9 Film G225 2-20-58 et

857

CERTIFICATE OF DEATH

00813

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN lb <u>56</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LUBANAN HOSPITAL</u>				d. STREET ADDRESS <u>1204 COLSTON DRIVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>William E. Gladstone Bishop</u>				4. DATE OF DEATH Month Day Year <u>1 26 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-11 1888</u>	9. AGE (In years last birthday) <u>69 1/4</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DISCOUNT STORE MGR.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CANADIAN NAT</u>		11. BIRTHPLACE (State or foreign country) <u>NOVA SCOTIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>CANADA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT (Name - in - law) Address <u>THOMAS N. ZAUER 4402 EVELITT ST KENSINGTON</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Coronary atherosclerotic heart disease</u> (b) <u>Ida.</u> (c) <u>3 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/2/58</u> 19___ to <u>1/26/58</u> 19___, that I last saw the deceased alive on <u>1/26/58</u> 19___, and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard Walsh</u> M.D. <u>900-17th St S.W.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1/28/58</u>			
PHYSICIAN'S NAME (Type) <u>Bernard J Walsh</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>Jan 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 3 Film G225 2/14/58 GTE
811
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sakima Park</i> c. LENGTH OF STAY IN 1b <i>years</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanatorium</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sakima Park</i> d. STREET ADDRESS <i>6403 Eastern Avenue</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Walter C. William Charles Bladen</i>		4. DATE OF DEATH <i>January 25, 1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 21, 1899</i>
9. AGE (In years last birthday) <i>58</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Not employed</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Washington DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Adam Thomas Bladen</i>		14. MOTHER'S MAIDEN NAME <i>Marion Ida Norton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>578-24-9039</i>	
17. INFORMANT <i>Mrs Florence Walters, 314 Faragut St NE</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> DUE TO <i>442x</i> Cardio-Vascular -Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Hypertension, Generalized</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Obesity, exogenous</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>October 26, 1956</i> , to <i>1-25-</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>1-25-</i> , 1958, and that death occurred at <i>2:20 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>A. Hillman</i>		M.D. <i>249 Missouri Avenue, N.W.</i>	
PHYSICIAN'S NAME (Type) <i>SAMUEL A. HILLMAN, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 28, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince George Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters, 254 Carroll St NW DC</i>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <i>JAN 29 '58</i>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

THE DEATH

NAME

DATE OF DEATH

AGE

PLACE OF DEATH

SEX

CAUSE OF DEATH

EDUCATION

DATE OF BIRTH

OCCUPATION

DATE OF DEATH

RELIGION

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

812 CERTIFICATE OF DEATH

00815

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>19 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. STREET ADDRESS <u>22 Manchester Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Boy</u> Last <u>of Alice Blorstad</u>		4. DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Boy</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 28, 1958</u>
9. AGE (In years last birthday) yrs. <u>19</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Odd Palmer Blorstad</u>		14. MOTHER'S MAIDEN NAME <u>Alice Perry Damon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mother's Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory obstruction</u> <u>759.0</u> DUE TO <u>Congenital stenosis of trachea and esophagus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>congenital stenosis of trachea and esophagus</u> (c) <u>congenital stenosis of trachea and esophagus</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Polyhydramnios</u> (b) <u>Permaternity</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/28</u> , 19 <u>58</u> , to <u>1/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/28</u> , 19 <u>58</u> , and that death occurred at <u>10:55 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond Chinn</u>		DATE SIGNED <u>1/29/58</u>	
PHYSICIAN'S NAME (Type) <u>Raymond Chinn, M.D.</u>		ADDRESS (Street, city or town, state) <u>925 Pershing Drive, Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1-29-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hosp. Takoma Park, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Lane M.D.</u>		ADDRESS <u>Washington Sanitarium & Hosp.</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>DATE</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

858

CERTIFICATE OF DEATH

00816

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4822 Leland Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MAY</u> Middle <u>WOODIN</u> Last <u>BOND</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/24/1873</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>4</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cyrus Woodin</u>				14. MOTHER'S MAIDEN NAME <u>Lura Kiesler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Everett Hessler</u> Address <u>same as 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> to <u>JAN 28, 1958</u> , that I last saw the deceased alive on <u>JANUARY 27, 1958</u> , and that death occurred at <u>1:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>DeWitt E. DeLauter</u> M.D. <u>8025 ABERDEEN RD BETHESDA, MD</u>				DATE SIGNED <u>1/28/58</u>			
PHYSICIAN'S NAME (Type) <u>DeWITT E. DeLauter</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>1/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Homesdale</u>		22d. LOCATION (City, town, or county) (State) <u>Homesdale, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>JAN 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u></u>	

BUREAU A. S.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Baltimore</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>		c. LENGTH OF STAY IN 1b <u>5 hrs - 35 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Box 88, Hamilton, Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>90 X 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby girl Bruce</u>				4. DATE OF DEATH <u>January 26 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/26/38</u>		9. AGE (In years last birthday) yrs. <u>19</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>5 35</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>mag. bond.</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John A. Bouene</u>				14. MOTHER'S MAIDEN NAME <u>Beatrice Tolon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>mother's chest - same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-26</u> , 1958, to <u>1-26</u> , 1958, that I last saw the deceased alive on <u>1-26</u> , 1958, and that death occurred at <u>20h</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Winston E. Cochran</u> M.D.				1-27-58			
PHYSICIAN'S NAME (Type) <u>Winston E. Cochran, M.D. 927 Pershing Dr. Silver Spring, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2-5-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hospital, Takoma Park, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Fox, MD</u> ADDRESS <u>Wash. San. & Hospital, Takoma Park, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Cochran</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 7 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO. 100

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF FUNERAL HOME</p>		<p>16. SIGNATURE OF BURIAL PLACE</p>	
<p>17. SIGNATURE OF VENDOR</p>		<p>18. SIGNATURE OF OTHER</p>	
<p>19. SIGNATURE OF OTHER</p>		<p>20. SIGNATURE OF OTHER</p>	
<p>21. SIGNATURE OF OTHER</p>		<p>22. SIGNATURE OF OTHER</p>	
<p>23. SIGNATURE OF OTHER</p>		<p>24. SIGNATURE OF OTHER</p>	
<p>25. SIGNATURE OF OTHER</p>		<p>26. SIGNATURE OF OTHER</p>	
<p>27. SIGNATURE OF OTHER</p>		<p>28. SIGNATURE OF OTHER</p>	
<p>29. SIGNATURE OF OTHER</p>		<p>30. SIGNATURE OF OTHER</p>	
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<p>41. SIGNATURE OF OTHER</p>		<p>42. SIGNATURE OF OTHER</p>	
<p>43. SIGNATURE OF OTHER</p>		<p>44. SIGNATURE OF OTHER</p>	
<p>45. SIGNATURE OF OTHER</p>		<p>46. SIGNATURE OF OTHER</p>	
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<p>57. SIGNATURE OF OTHER</p>		<p>58. SIGNATURE OF OTHER</p>	
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<p>99. SIGNATURE OF OTHER</p>		<p>100. SIGNATURE OF OTHER</p>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

00818

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE _____ b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BURTENVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		d. STREET ADDRESS <u>7943 ORCHID ST. NW</u>	
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>-</u> Last <u>BRICK</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WH.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB-4-1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>-</u>	
14. MOTHER'S MAIDEN NAME <u>-</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>GOLDA BECKER - 7943 ORCHID ST. NW DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 443X DUE TO <u>Hypertensive and Arteriosclerotic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral vascular Disease</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1.5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Sept 10, 1957</u> to <u>Jan 25, 1958</u> , that I last saw the deceased alive on <u>Jan 25, 1958</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Benjamin Isaacson</u>		ADDRESS (Street, city or town, state) <u>7733 Alaska Ave NW Washington DC</u>	
PHYSICIAN'S NAME (Type) _____		DATE SIGNED <u>1/25/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan 26 '58</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial</u>	22d. LOCATION (City, town, or county) <u>Virginia Falls Church</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>		ADDRESS <u>4217 5th NW</u>	
24a. REC'D BY REGISTRAR <u>Al. Beach</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Beach</u>	
DATE <u>JAN 29 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

JAN 29 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please exercise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00819

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville. Rural		c. LENGTH OF STAY in lb 40 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Travilla Rd.		e. STREET ADDRESS Travilla Rd.	
3. NAME OF DECEASED (Type or print) Samuel Remus Briggs		4. DATE OF DEATH Jan. 27, 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1883
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Briggs		14. MOTHER'S MAIDEN NAME Drusilla Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Ernest C. Briggs, Gaithersburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Found dead at home sitting in living room chair		INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Jan. 28, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-58	
22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.		24a. REC'D BY REGISTRAR DATE JAN 30 '58	
24b. REGISTRAR'S SIGNATURE W. H. Smith			

RECEIVED

JAN 30 1958

BUREAU V. B.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

861

CERTIFICATE OF DEATH

00820

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Anna</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 16, 1907</u>
9. AGE (In years lost birth day) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin McKinney</u>		14. MOTHER'S MAIDEN NAME <u>Mary Culley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Russell Brown</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>171X</u> DUE TO <u>Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Epidermoid Carcinoma of Cervix Uteri</u> DUE TO (c) <u>7 mos</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/2</u> , 19 <u>58</u> , to <u>1/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/14</u> , 19 <u>58</u> , and that death occurred at <u>10 A</u> . M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frederick Y. Donn</u> M.D.		ADDRESS (Street, city or town, state) <u>1835 I St., N.W.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Frederick Y. Donn</u>		<u>Wash. D.C.</u>	
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>		24a. REGISTRY REGISTRAR DATE <u>JAN 21 1958</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

862 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00821

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia	c. LENGTH OF STAY in lb life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md. R-27 Montg Co.		d. STREET ADDRESS Md R-27 Montg. Co.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Della Middle A. Last Burdette		4. DATE OF DEATH Month Jan Day 28 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1891
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank Watkins	
14. MOTHER'S MAIDEN NAME Fidelia Reed		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. --		17. INFORMANT Bates E. Watkins, Monrovia, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 975X DUE TO Conditions, if any, which gave rise to immediate cause (b) drowning (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Found dead in partly filled bath tub of her home			INTERVAL BETWEEN ONSET AND DEATH Found dead in bath tub
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) Found dead in partly filled bath tub of her home	
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Jan. 29, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 31, 1958	22c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.	22d. LOCATION (City, town, or county) (State) Clagettville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Mohrman		24a. REC'D BY REGISTRAR Damascus, Md.	24b. REGISTRAR'S SIGNATURE Feb 3 '58

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

DATE OF DEATH

RESIDENCE

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

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BUREAU V. S.

FEB 3 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00822

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

863

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia	c. LENGTH OF STAY IN 1b life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md. R -27 Montg. Co.		d. STREET ADDRESS Md. - 27 Montg. Co.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Robert E. Burdette		4. DATE OF DEATH Jan. 29, 1958	Year 19
5. SEX male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Md.	11. BIRTHPLACE (State or foreign country) USA
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Perry G. Burdette	
14. MOTHER'S MAIDEN NAME Lucinda Becraft		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 212-32-3116		17. INFORMANT Amos D. Burdette, Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia 974x DUE TO hanging Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hanging DUE TO (c) hanging INTERVAL BETWEEN ONSET AND DEATH Found hanging in home		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found hanging in basement of his home	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED Jan. 29, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 31, 1958	22c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.	22d. LOCATION (City, town, or county) (State) Clagetsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. McManis		24a. REC'D BY REGISTRAR DATE FEB 3 '58	
ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE Oliver L. McManis	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPT. OF HEALTH
BALTIMORE

RECEIVED
FEB 3 1938
BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

864

CERTIFICATE OF DEATH

Reg. Dist. No.

00823

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boys - RFD</u>		c. LENGTH OF STAY IN 1b <u>77 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Boys - Rural</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>D</u> Last <u>BYRD</u>		4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 2 - 1880</u> 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Owns Farm - Active</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>77</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John B. Byrd</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Veirs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>615-36-5767</u>	
17. INFORMANT Address <u>Mrs Joseph Byrd, Boys - RFD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary congestion</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic congestive heart failure</u> DUE TO (c) <u>Hypertensive Cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>1 year</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>D diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>18 Feb., 1948</u> , to <u>8 Jan., 1958</u> , that I last saw the deceased alive on <u>6 Jan., 1958</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John G. Fawcett</u> M.D. <u>DANSONVILLE P.O. Byrd, Md</u> 1/8/58		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JOHN G. FAWCETT M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/10/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>	22d. LOCATION (City, town, or county) (State) <u>Beallville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u> ADDRESS <u>Burrowsville, Md</u>		24a. REC'D BY REGISTRAR <u>W. Beach</u>	24b. REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

Page 1 of 1

1. NAME OF DECEASED JOSEPH A. DUNN		2. SEX M		3. AGE 68		4. DATE OF BIRTH 1881		5. PLACE OF BIRTH MD	
6. OCCUPATION None		7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF DEATH Home		10. DATE OF DEATH Jan 10 1953	
11. SIGNATURE OF DECEASED None		12. SIGNATURE OF NEXT OF KIN None		13. SIGNATURE OF PHYSICIAN None		14. SIGNATURE OF CLERK None		15. SIGNATURE OF REGISTRAR None	
16. NAME OF PHYSICIAN None		17. NAME OF CLERK None		18. NAME OF REGISTRAR None		19. NAME OF DECEASED JOSEPH A. DUNN		20. NAME OF NEXT OF KIN None	
21. NAME OF PHYSICIAN None		22. NAME OF CLERK None		23. NAME OF REGISTRAR None		24. NAME OF DECEASED JOSEPH A. DUNN		25. NAME OF NEXT OF KIN None	
26. NAME OF PHYSICIAN None		27. NAME OF CLERK None		28. NAME OF REGISTRAR None		29. NAME OF DECEASED JOSEPH A. DUNN		30. NAME OF NEXT OF KIN None	
31. NAME OF PHYSICIAN None		32. NAME OF CLERK None		33. NAME OF REGISTRAR None		34. NAME OF DECEASED JOSEPH A. DUNN		35. NAME OF NEXT OF KIN None	
36. NAME OF PHYSICIAN None		37. NAME OF CLERK None		38. NAME OF REGISTRAR None		39. NAME OF DECEASED JOSEPH A. DUNN		40. NAME OF NEXT OF KIN None	
41. NAME OF PHYSICIAN None		42. NAME OF CLERK None		43. NAME OF REGISTRAR None		44. NAME OF DECEASED JOSEPH A. DUNN		45. NAME OF NEXT OF KIN None	
46. NAME OF PHYSICIAN None		47. NAME OF CLERK None		48. NAME OF REGISTRAR None		49. NAME OF DECEASED JOSEPH A. DUNN		50. NAME OF NEXT OF KIN None	
51. NAME OF PHYSICIAN None		52. NAME OF CLERK None		53. NAME OF REGISTRAR None		54. NAME OF DECEASED JOSEPH A. DUNN		55. NAME OF NEXT OF KIN None	
56. NAME OF PHYSICIAN None		57. NAME OF CLERK None		58. NAME OF REGISTRAR None		59. NAME OF DECEASED JOSEPH A. DUNN		60. NAME OF NEXT OF KIN None	
61. NAME OF PHYSICIAN None		62. NAME OF CLERK None		63. NAME OF REGISTRAR None		64. NAME OF DECEASED JOSEPH A. DUNN		65. NAME OF NEXT OF KIN None	
66. NAME OF PHYSICIAN None		67. NAME OF CLERK None		68. NAME OF REGISTRAR None		69. NAME OF DECEASED JOSEPH A. DUNN		70. NAME OF NEXT OF KIN None	
71. NAME OF PHYSICIAN None		72. NAME OF CLERK None		73. NAME OF REGISTRAR None		74. NAME OF DECEASED JOSEPH A. DUNN		75. NAME OF NEXT OF KIN None	
76. NAME OF PHYSICIAN None		77. NAME OF CLERK None		78. NAME OF REGISTRAR None		79. NAME OF DECEASED JOSEPH A. DUNN		80. NAME OF NEXT OF KIN None	
81. NAME OF PHYSICIAN None		82. NAME OF CLERK None		83. NAME OF REGISTRAR None		84. NAME OF DECEASED JOSEPH A. DUNN		85. NAME OF NEXT OF KIN None	
86. NAME OF PHYSICIAN None		87. NAME OF CLERK None		88. NAME OF REGISTRAR None		89. NAME OF DECEASED JOSEPH A. DUNN		90. NAME OF NEXT OF KIN None	
91. NAME OF PHYSICIAN None		92. NAME OF CLERK None		93. NAME OF REGISTRAR None		94. NAME OF DECEASED JOSEPH A. DUNN		95. NAME OF NEXT OF KIN None	
96. NAME OF PHYSICIAN None		97. NAME OF CLERK None		98. NAME OF REGISTRAR None		99. NAME OF DECEASED JOSEPH A. DUNN		100. NAME OF NEXT OF KIN None	

RECEIVED
JAN 10 1953
BUREAU V. S.

865

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9304 Lindale Drive				d. STREET ADDRESS 9304 Lindale Drive			
3. NAME OF DECEASED (Type or print) First Middle Last Marion Billington Carter				4. DATE OF DEATH Month Day Year Jan. 26 19 58			
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1876		9. AGE (In years lost birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY US Govt.		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levi O. Billington				14. MOTHER'S MAIDEN NAME Marion Loomis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Sidney F. Malone		Address 9304 Lindale Dr. Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchopneumonia 334X DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) 7 years INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 2, 19 50 to January 26, 19 58 , that I last saw the deceased alive on January 24, 19 58 , and that death occurred at 1:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert G. Angle				DATE SIGNED 1/26/58			
PHYSICIAN'S NAME (Type) Robert G. Angle, M.D.				ADDRESS (Street, city or town, state) 5009 Del Ray Avenue, Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 1/27/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gauders				24a. REC'D BY REGISTRAR JAN 28 '58		24b. REGISTRAR'S SIGNATURE Quincy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 28 1958
BUREAU V. 1

JAN 28 1959

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

00825

866

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Germanstown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Germanstown</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Martin Luther Catron</i>		4. DATE OF DEATH <i>January 9-1958</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 15-1893</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>janitor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>public school</i>	11. BIRTHPLACE (State or foreign country) <i>Blanco Co., Virginia</i>
13. FATHER'S NAME <i>John Stonger Catron</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Ann Burkett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <i>yes 1918</i>		16. SOCIAL SECURITY NO. <i>229-03-8986</i>	
17. INFORMANT <i>Myrtle M. Catron</i>		Address <i>Germanstown, Md. Route 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Atherosclerosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan-7-</i> , 1958, to <i>Jan-9-</i> , 1958, that I last saw the deceased alive on <i>January-8-</i> , 1958, and that death occurred at <i>4:30 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William C. Miller</i>		DATE SIGNED <i>7- Brooks Avenue</i>	
PHYSICIAN'S NAME (Type) <i>William C. Miller</i>		Address <i>Gaithersburg, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-11-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Goodman's Chapel</i>	22d. LOCATION (City, town, or county) (State) <i>Chathamville Va</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Emmett E. Gaither</i>		ADDRESS <i>Gaithersburg Md</i>	
24a. REC'D BY REGISTRAR <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>—</i>	
DATE <i>JAN 13 '58</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11/11/11

2. 1891

1. 100

W. Hall

117

2150

5. 10. 1941

2771-52-1000

100

Side 2

Blanchard, E. J.

John Edgar Hoover

[Faint handwritten text at the bottom of the page]

1815

10-11-55

Trichostema album

simulated

BUREAU V. S.

8264-87-NAN-13-1958

RECEIVED

William C. Miller

7-10-1919

... ..



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

867

CERTIFICATE OF DEATH

00826

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) High Point 70x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 207 Bymun Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Wyatt Middle Carl Last Chandler		4. DATE OF DEATH Month January Day 28 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1898
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR: Months 59 Days 59 Hours 59 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Law Enforcement	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (unknown) Chandler		14. MOTHER'S MAIDEN NAME Liza Towns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 194x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) TRACHEAL OBSTRUCTION (c) GIANT CELL CARCINOMA OF THYROID		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 2 WEEKS 9 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 2, 1958 , to January 28, 1958 , that I last saw the deceased alive on January 28, 1958 , and that death occurred 04:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/28/58			
ACTUAL SIGNATURE Richard K. Shaw M.D.		National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Richard K. Shaw, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 1/29/58	22c. NAME OF CEMETERY OR CREMATORY High Point NC	
23. FUNERAL DIRECTOR'S SIGNATURE FRAZIER		24a. REC'D BY REGISTRAR 389. R I 24b. REGISTRAR'S SIGNATURE W. H. H. 3	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 1-1-58

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. RACE [Faint text]		5. DATE OF BIRTH [Faint text]	
6. PLACE OF BIRTH [Faint text]		7. MARITAL STATUS [Faint text]		8. OCCUPATION [Faint text]		9. CAUSE OF DEATH [Faint text]		10. MANNER OF DEATH [Faint text]	
11. SIGNATURE OF DECEASED [Faint text]		12. SIGNATURE OF WITNESS [Faint text]		13. SIGNATURE OF PHYSICIAN [Faint text]		14. SIGNATURE OF CORONER [Faint text]		15. SIGNATURE OF JURY [Faint text]	
16. SIGNATURE OF DECEASED [Faint text]		17. SIGNATURE OF WITNESS [Faint text]		18. SIGNATURE OF PHYSICIAN [Faint text]		19. SIGNATURE OF CORONER [Faint text]		20. SIGNATURE OF JURY [Faint text]	
21. SIGNATURE OF DECEASED [Faint text]		22. SIGNATURE OF WITNESS [Faint text]		23. SIGNATURE OF PHYSICIAN [Faint text]		24. SIGNATURE OF CORONER [Faint text]		25. SIGNATURE OF JURY [Faint text]	
26. SIGNATURE OF DECEASED [Faint text]		27. SIGNATURE OF WITNESS [Faint text]		28. SIGNATURE OF PHYSICIAN [Faint text]		29. SIGNATURE OF CORONER [Faint text]		30. SIGNATURE OF JURY [Faint text]	
31. SIGNATURE OF DECEASED [Faint text]		32. SIGNATURE OF WITNESS [Faint text]		33. SIGNATURE OF PHYSICIAN [Faint text]		34. SIGNATURE OF CORONER [Faint text]		35. SIGNATURE OF JURY [Faint text]	
36. SIGNATURE OF DECEASED [Faint text]		37. SIGNATURE OF WITNESS [Faint text]		38. SIGNATURE OF PHYSICIAN [Faint text]		39. SIGNATURE OF CORONER [Faint text]		40. SIGNATURE OF JURY [Faint text]	
41. SIGNATURE OF DECEASED [Faint text]		42. SIGNATURE OF WITNESS [Faint text]		43. SIGNATURE OF PHYSICIAN [Faint text]		44. SIGNATURE OF CORONER [Faint text]		45. SIGNATURE OF JURY [Faint text]	
46. SIGNATURE OF DECEASED [Faint text]		47. SIGNATURE OF WITNESS [Faint text]		48. SIGNATURE OF PHYSICIAN [Faint text]		49. SIGNATURE OF CORONER [Faint text]		50. SIGNATURE OF JURY [Faint text]	
51. SIGNATURE OF DECEASED [Faint text]		52. SIGNATURE OF WITNESS [Faint text]		53. SIGNATURE OF PHYSICIAN [Faint text]		54. SIGNATURE OF CORONER [Faint text]		55. SIGNATURE OF JURY [Faint text]	
56. SIGNATURE OF DECEASED [Faint text]		57. SIGNATURE OF WITNESS [Faint text]		58. SIGNATURE OF PHYSICIAN [Faint text]		59. SIGNATURE OF CORONER [Faint text]		60. SIGNATURE OF JURY [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF WITNESS [Faint text]		63. SIGNATURE OF PHYSICIAN [Faint text]		64. SIGNATURE OF CORONER [Faint text]		65. SIGNATURE OF JURY [Faint text]	
66. SIGNATURE OF DECEASED [Faint text]		67. SIGNATURE OF WITNESS [Faint text]		68. SIGNATURE OF PHYSICIAN [Faint text]		69. SIGNATURE OF CORONER [Faint text]		70. SIGNATURE OF JURY [Faint text]	
71. SIGNATURE OF DECEASED [Faint text]		72. SIGNATURE OF WITNESS [Faint text]		73. SIGNATURE OF PHYSICIAN [Faint text]		74. SIGNATURE OF CORONER [Faint text]		75. SIGNATURE OF JURY [Faint text]	
76. SIGNATURE OF DECEASED [Faint text]		77. SIGNATURE OF WITNESS [Faint text]		78. SIGNATURE OF PHYSICIAN [Faint text]		79. SIGNATURE OF CORONER [Faint text]		80. SIGNATURE OF JURY [Faint text]	
81. SIGNATURE OF DECEASED [Faint text]		82. SIGNATURE OF WITNESS [Faint text]		83. SIGNATURE OF PHYSICIAN [Faint text]		84. SIGNATURE OF CORONER [Faint text]		85. SIGNATURE OF JURY [Faint text]	
86. SIGNATURE OF DECEASED [Faint text]		87. SIGNATURE OF WITNESS [Faint text]		88. SIGNATURE OF PHYSICIAN [Faint text]		89. SIGNATURE OF CORONER [Faint text]		90. SIGNATURE OF JURY [Faint text]	
91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF WITNESS [Faint text]		93. SIGNATURE OF PHYSICIAN [Faint text]		94. SIGNATURE OF CORONER [Faint text]		95. SIGNATURE OF JURY [Faint text]	
96. SIGNATURE OF DECEASED [Faint text]		97. SIGNATURE OF WITNESS [Faint text]		98. SIGNATURE OF PHYSICIAN [Faint text]		99. SIGNATURE OF CORONER [Faint text]		100. SIGNATURE OF JURY [Faint text]	

BUREAU V. 1

FEB 3 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 110827

868

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle ELLEN Last CLARK				4. DATE OF DEATH Month Jan. Day 11 Year 1958			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 22, 1894	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Samuel Johnson				14. MOTHER'S MAIDEN NAME Anna V. Carter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Miss Elsie Clark Address Sandy Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/15 , 19 57 , to 1/11/58 , 19 58 , that I last saw the deceased alive on 1/11/58 , 19 58 , and that death occurred at 7 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Md. DATE SIGNED 1/12/58							
ACTUAL SIGNATURE Patriok C. Jameson M.D.				PHYSICIAN'S NAME (Type) Patriok C. Jameson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/58		22c. NAME OF CEMETERY OR CREMATORY Sandy Spring.		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE JAN 20 '58	
24b. REGISTRAR'S SIGNATURE W. Beach							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 10

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF CORONER</p>		<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESSES</p>		<p>15. SIGNATURE OF DECEASED</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF DECEASED</p>		<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF DECEASED</p>		<p>25. SIGNATURE OF DECEASED</p>	
<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF DECEASED</p>		<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF DECEASED</p>		<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF DECEASED</p>	
<p>36. SIGNATURE OF DECEASED</p>		<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF DECEASED</p>		<p>39. SIGNATURE OF DECEASED</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF DECEASED</p>		<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF DECEASED</p>		<p>45. SIGNATURE OF DECEASED</p>	
<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF DECEASED</p>		<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF DECEASED</p>	
<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF DECEASED</p>		<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF DECEASED</p>		<p>55. SIGNATURE OF DECEASED</p>	
<p>56. SIGNATURE OF DECEASED</p>		<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF DECEASED</p>		<p>64. SIGNATURE OF DECEASED</p>		<p>65. SIGNATURE OF DECEASED</p>	
<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF DECEASED</p>		<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF DECEASED</p>		<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF DECEASED</p>		<p>75. SIGNATURE OF DECEASED</p>	
<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF DECEASED</p>		<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF DECEASED</p>		<p>85. SIGNATURE OF DECEASED</p>	
<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF DECEASED</p>		<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF DECEASED</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF DECEASED</p>		<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF DECEASED</p>	
<p>96. SIGNATURE OF DECEASED</p>		<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF DECEASED</p>		<p>99. SIGNATURE OF DECEASED</p>		<p>100. SIGNATURE OF DECEASED</p>	

BUREAU V. S.

JAN 20 1959

RECEIVED

869

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Joseph Middle CLARK Last CLARK		4. DATE OF DEATH Month January Day 31 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 January 1958
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph John CLARK		14. MOTHER'S MAIDEN NAME Phyllis Marie ROSSER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Joseph J. CLARK (Same as #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency DUE TO 769.6 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Hyaline Membrane Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Premature birth of diabetic mother		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 January, 19 58 to 31 January, 19 58 , that I last saw the deceased alive on 31 January, 19 58 , and that death occurred at 8:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED			
ACTUAL SIGNATURE Adam G. Thorp Jr. M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Adam G. Thorp, Jr. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-4-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey R.A. Humphrey, 7550 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR FEB 6 '58	
24b. REGISTRAR'S SIGNATURE Robert A. Humphrey			

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BUREAU V. 3

FEB 6 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

Item 12 Film 225 2-3-58 et

814

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00830

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>804-Maplewood Ave.</u>		d. STREET ADDRESS <u>7106 Central Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>Eyton</u> Last <u>CLARKE</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/2/1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Japan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Latham Owen Eyton</u>		14. MOTHER'S MAIDEN NAME <u>Kiyo Hijikata</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>4</u>	
17. INFORMANT <u>Mrs Sylvia MacKinnon</u> Address <u>Daughter</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma of Left Lung</u> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>about 2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/20</u> , 19 <u>58</u> , to <u>1/24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/20</u> , 19 <u>58</u> , and that death occurred at <u>5:10 p.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Aud</u> M.D.		ADDRESS (Street, city or town, state) <u>9026 Leesville Rd Silver Spring, Md</u> DATE SIGNED <u>1/24/58</u>	
PHYSICIAN'S NAME (Type) <u>William D. Aud</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Lee & Sons</u> ADDRESS <u>300 4th N. E.</u>		24a. REC'D BY REGISTRAR <u>JAN 29 58</u> DATE <u>2/1/58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. S. Leach</u>			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

FILE NO.

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

REGISTRAR

DATE

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BUREAU V. S.

JAN 29 1939

RECEIVED

1-24-39

871

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Norfolk</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN IB <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>401 Westover</u>			
3. NAME OF DECEASED (Type or print) First <u>Charlotte</u> Middle <u>Elizabeth</u> Last <u>Cook</u>				4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>19 58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-11-80</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>77</u> Days <u>3</u> Hours <u>19</u> Min. <u>58</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Music Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired-</u>		11. BIRTHPLACE (State or foreign country) <u>Ludow, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George E. Jewett</u>				14. MOTHER'S MAIDEN NAME <u>Grace Kelley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Elmer A. Cook</u>		17. INFORMANT Address <u>(Same) Husband</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u> <u>464X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PHLEBOTROMBOSIS</u> DUE TO (c) <u>2 days</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subendocardial myocardial infarction</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>26 Dec</u> , 19 <u>57</u> , to <u>JAN 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/2</u> , 19 <u>58</u> , and that death occurred at <u>5:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles J. Savarese</u> M.D.		ADDRESS (Street, city or town, state) <u>4890 Battle Lane Bethesda, Md.</u>		DATE SIGNED <u>1/3/58</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 1-7-58</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Norfolk, Virginia.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

211

1. NAME OF DECEASED JOHN J. ROBERTS		2. SEX Male		3. AGE 45	
4. DATE OF DEATH Jan 7 1958		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md	
10. OCCUPATION Salesman		11. MARITAL STATUS Married		12. EDUCATION High School	
13. PREVIOUS ILLNESS Hypertension		14. MEDICAL HISTORY None		15. PHYSICIAN'S SIGNATURE [Signature]	
16. SIGNATURE OF NEXT OF KIN [Signature]		17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF WITNESSES [Signatures]	

BUREAU V. S.

JAN 7 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

815

CERTIFICATE OF DEATH

Reg. Dist. No.

00832

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington, 1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>		d. STREET ADDRESS <u>11113 Midvale Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Effie</u> Middle <u>Ann</u> Last <u>Cooley</u>		4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30, 1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel Mills</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Odden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the gallbladder</u> <u>155.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4936 Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 10, 1957</u> to <u>Jan. 12, 1958</u> , that I last saw the deceased alive on <u>Jan. 12, 1958</u> , and that death occurred at <u>6:25 A</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Seruch T. Kimble</u>		M.D. <u>929 Pershing Drive, Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble</u>		<u>929 Pershing Drive, S. S.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Clarksburg Church</u>		22d. LOCATION (City, town, or county) (State) <u>Clarksburg Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JAN 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Beach</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

File No.

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. RACE [REDACTED]		5. DATE OF BIRTH [REDACTED]		6. PLACE OF BIRTH [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. OCCUPATION [REDACTED]		9. CAUSE OF DEATH [REDACTED]		10. MANNER OF DEATH [REDACTED]		11. PLACE OF DEATH [REDACTED]		12. TIME OF DEATH [REDACTED]	
13. SIGNATURE OF DECEASED [REDACTED]		14. SIGNATURE OF WITNESS [REDACTED]		15. SIGNATURE OF PHYSICIAN [REDACTED]		16. SIGNATURE OF CORONER [REDACTED]		17. SIGNATURE OF JURY [REDACTED]		18. SIGNATURE OF JUDGE [REDACTED]	
19. SIGNATURE OF DECEASED [REDACTED]		20. SIGNATURE OF WITNESS [REDACTED]		21. SIGNATURE OF PHYSICIAN [REDACTED]		22. SIGNATURE OF CORONER [REDACTED]		23. SIGNATURE OF JURY [REDACTED]		24. SIGNATURE OF JUDGE [REDACTED]	

BUREAU V. 3

JAN. 14. 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 9 Film G225 1-30-58 et

CERTIFICATE OF DEATH

00833

Reg. Dist. No.

872

1. PLACE OF DEATH a. COUNTY <u>Montg.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Middlecoff</u> Last <u>Corbett</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 21-1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinest.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Industrial Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Abraham Corbett</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Rebecca Lesman, Germantown Md.</u>	
17. INFORMANT <u>Rebecca Lesman, Germantown Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Calcinoma colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 months</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 21</u> , 19 <u>57</u> , to <u>Jan 21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 21</u> , 19 <u>58</u> , and that death occurred at <u>6:58 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vernon E. Martens</u> M.D.		ADDRESS (Street, city or town, state) <u>Germantown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Vernon E. Martens</u>		DATE SIGNED <u>1-21-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-23-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg. Md.</u>		ADDRESS <u>Gaithersburg. Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

2

BOREAU & SONS

JAN 23 1961

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

873

CERTIFICATE OF DEATH

Reg. Dist. No.

00834

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 73 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 6605 - 44th Avenue			
3. NAME OF DECEASED (Type or print) First Rena Middle Ardell Last Cramton				4. DATE OF DEATH Month January Day 12 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 3, 1884	
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 7 Days 16 Hours 8 Min.		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mender				10b. KIND OF BUSINESS OR INDUSTRY Woolen Mill			
13. FATHER'S NAME Samuel Bingham				14. MOTHER'S MAIDEN NAME Nellie Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Insufficiency DUE TO 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic malignant Carcinoid Tumor DUE TO 18 mo (c) 1 1/2 mo							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October 31, 1957 , to January 12, 1958 , that I last saw the deceased alive on January 12, 1958 , and that death occurred at 1:47 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/12/58 ACTUAL SIGNATURE Thomas N. Lynn, Jr. M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Thomas N. Lynn, Jr., M.D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 1/13/58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Lawrence		22d. LOCATION (City, town, or county) (State) Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville Md.				24a. REC'D BY REGISTRAR JAN 17 '58		24b. REGISTRAR'S SIGNATURE Overbaugh	

CERTIFICATE OF DEATH

For Use of

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
The Clinical Center, between 11th and 12th Avenues		Male		35		White		October 21, 1958		Baltimore, Maryland	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Date of Report		Signature of Registrar	
Ischemic heart disease		Myocardial infarction		Coronary atherosclerosis		Natural		October 22, 1958		[Signature]	
Place of Birth		Date of Birth		Date of Admission		Date of Discharge		Date of Death		Date of Report	
Baltimore, Maryland		October 15, 1923		October 15, 1958		October 15, 1958		October 21, 1958		October 22, 1958	
Name of Physician		Name of Hospital		Name of Doctor		Name of Nurse		Name of Mortician		Name of Registrar	
[Signature]		The Clinical Center		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. E.

JAN 17 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be ordered to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 810 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00835

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring,</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hosp.</u>				d. STREET ADDRESS <u>8902 Bradford Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ISREAL (NONE) DANKER</u>				4. DATE OF DEATH Month Day Year <u>June 6 - 1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV-9-1885</u>	9. AGE (In years last birthday) <u>72 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dentistry</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>MR. BERNARD (NMN) DANKER</u>				14. MOTHER'S MARDEN NAME <u>Michelson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>MR. George Steiner - Takoma Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>7:30</u> a.m. <u>1-6</u> 19 <u>58</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Bernard H. Ostrow</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Mc</u>				ADDRESS <u>2100 Euteria Pl</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF VENDOR		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF BURIAL		23. SIGNATURE OF CREMATION		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. S.

JAN 9 1958

RECEIVED

817

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>1</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-25-86</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>4</u> Min. <u>15</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>4</u> Min. <u>15</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>			
11. BIRTHPLACE (State or foreign country) <u>N. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William P. Davis</u>				14. MOTHER'S MAIDEN NAME <u>Alice Trevaathan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Washington Sanitarium & Hosp Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446x</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>probably</u> <u>years</u> <u>probably</u> <u>years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>November 1957</u> to <u>January 4, 1958</u> that I last saw the deceased alive on <u>January 4, 1958</u> , and that death occurred at <u>6:48 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arnon H. Traum</u>				DATE SIGNED <u>Jan 5 '58</u>			
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>				ADDRESS (Street, city or town, state) <u>8237 Georgia Ave - Silver Spring Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>				22b. DATE THEREOF <u>1/7/58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>PINEVIEW CEMETERY</u>				22d. LOCATION (City, town, or county) (State) <u>ROCKY MOUNT, NORTH CAROLINA</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>			
24a. REC'D BY REGISTRAR <u>Alb. Leach</u>				24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>			

CERTIFICATE OF DEATH

Page No. 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF DEATH		14. DATE OF DEATH		15. TIME OF DEATH	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	

BUREAU V. S.

1958

RECEIVED

870

CERTIFICATE OF DEATH

00829

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. LENGTH OF STAY IN 1b <i>6 hrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				e. STREET ADDRESS <i>3931 Newdale Road</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Ruby Clark Delashmuth</i>				4. DATE OF DEATH Month Day Year <i>1 31 1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 18, 1884</i>	
9. AGE (In years last birthday) <i>73</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. <i>9 13</i>		11. IF UNDER 24 HRS. <i>7 13</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>			
11. BIRTHPLACE (State or foreign country) <i>New York</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Reuben Clark</i>				14. MOTHER'S MAIDEN NAME <i>Fannie Dorsey</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>None</i>			
17. INFORMANT <i>Sen-Wibbian P Delashmuth</i>				Address <i>6000 Maiden Lane Bethesda</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis, lungs and left chest</i> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastatic carcinoma left breast wall</i> DUE TO (c) <i>2 mos + 2 1/2 years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Myocardial degeneration, diffuse bilat</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>1946</i> , to <i>Jan 31</i> , 1958, that I last saw the deceased alive on <i>Jan 31</i> , 1958, and that death occurred at <i>9:15 PM</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>3921 Ingomar St NW Wash 15 DC</i>							
DATE SIGNED <i>1/31/58</i>							
ACTUAL SIGNATURE <i>Stewart Class</i> M.D.							
PHYSICIAN'S NAME (Type) <i>Stewart Class</i> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/3/1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> ADDRESS <i>7557 Wis. Ave. Beth. Md.</i>				24a. REC'D BY REGISTRAR <i>FEB 3 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

874

CERTIFICATE OF DEATH

00837

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 78 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
f. STREET ADDRESS 13009 Disney Lane		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Belle Middle Esther Last Disney		4. DATE OF DEATH Month January Day 15 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1898
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59	IF UNDER 24 HRS. Days 15 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby sitter & Homemaker own home		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T. Coar		14. MOTHER'S MAIDEN NAME Mary E. Burton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 Acute Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 204.3 DUE TO (c) 204.3		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 29, 1957 , to January 15, 1958 , that I last saw the deceased alive on January 15, 1958 , and that death occurred on 10:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Roger Lester		M.D. The Clinical Center 1/15/58	
PHYSICIAN'S NAME (Type) Roger Lester, M.D.		The National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/18/58	22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE UNION CEMETERY	22d. LOCATION (City, town, or county) (State) BURTONSVILLE, Montgomery Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Humphrey		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR JAN 20 '58		24b. REGISTRAR'S SIGNATURE W. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED JAMES M. JONES		2. SEX Male		3. AGE 35		4. RACE White		5. BIRTH DATE 1928		6. BIRTH PLACE Baltimore, Md.		7. MARRIAGE DATE 1950		8. MARRIAGE PLACE Baltimore, Md.	
9. DECEASED'S ADDRESS 1234 Main St. Baltimore, Md.		10. DECEASED'S OCCUPATION Salesman		11. DECEASED'S EDUCATION High School		12. DECEASED'S RELIGION Roman Catholic		13. DECEASED'S MARITAL STATUS Married		14. DECEASED'S SOCIAL SECURITY NUMBER 123-45-6789		15. DECEASED'S VETERAN STATUS None		16. DECEASED'S SERVICE NUMBER None	
17. DECEASED'S DATE OF DEATH Jan 20, 1958		18. DECEASED'S TIME OF DEATH 10:00 AM		19. DECEASED'S PLACE OF DEATH Home		20. DECEASED'S CAUSE OF DEATH Heart Disease		21. DECEASED'S MANNER OF DEATH Natural		22. DECEASED'S SIGNATURE James M. Jones		23. DECEASED'S ADDRESS 1234 Main St. Baltimore, Md.		24. DECEASED'S PHONE NUMBER 123-4567	
25. DECEASED'S NEXT OF KIN John M. Jones		26. DECEASED'S NEXT OF KIN ADDRESS 1234 Main St. Baltimore, Md.		27. DECEASED'S NEXT OF KIN PHONE NUMBER 123-4567		28. DECEASED'S NEXT OF KIN OCCUPATION Salesman		29. DECEASED'S NEXT OF KIN EDUCATION High School		30. DECEASED'S NEXT OF KIN RELIGION Roman Catholic		31. DECEASED'S NEXT OF KIN MARITAL STATUS Married		32. DECEASED'S NEXT OF KIN SERVICE NUMBER None	
33. DECEASED'S SIGNATURE James M. Jones		34. DECEASED'S ADDRESS 1234 Main St. Baltimore, Md.		35. DECEASED'S PHONE NUMBER 123-4567		36. DECEASED'S OCCUPATION Salesman		37. DECEASED'S EDUCATION High School		38. DECEASED'S RELIGION Roman Catholic		39. DECEASED'S MARITAL STATUS Married		40. DECEASED'S SERVICE NUMBER None	

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JAN 20 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00838

818

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hanora Theresa Donoghue				4. DATE OF DEATH Month Day Year January 23 1958			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-29-84	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hswf				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Mass.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME James Maloney				14. MOTHER'S MAIDEN NAME Mary Cunningham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from December 1957 to January 1958 , that I last saw the deceased alive on January 23, 1958 , and that death occurred at 10:58 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1019 University Boulevard, Silver Spring, Maryland DATE SIGNED 1/23/58 ACTUAL SIGNATURE Boris Rabkin M.D. PHYSICIAN'S NAME (Type) BORIS RABKIN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/27/58		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR JAN 27 '58		24b. REGISTRAR'S SIGNATURE Deborah	

CERTIFICATE OF DEATH

218

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE, MD.	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1905		BALTIMORE, MD.		JAMES H. HARRIS		1915		BALTIMORE, MD.	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
LABORER		1915		BALTIMORE, MD.		BALTIMORE, MD.		1915		BALTIMORE, MD.	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		1915		BALTIMORE, MD.		BALTIMORE, MD.		1915		BALTIMORE, MD.	
MANNER OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
NATURAL		1915		BALTIMORE, MD.		BALTIMORE, MD.		1915		BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		1915		BALTIMORE, MD.		BALTIMORE, MD.		1915		BALTIMORE, MD.	
SIGNATURE OF DECEASED		DATE		PLACE		NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		1915		BALTIMORE, MD.		BALTIMORE, MD.		1915		BALTIMORE, MD.	
SIGNATURE OF WITNESS		DATE		PLACE		NAME OF WITNESS		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		1915		BALTIMORE, MD.		BALTIMORE, MD.		1915		BALTIMORE, MD.	
SIGNATURE OF DECEASED		DATE		PLACE		NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		1915		BALTIMORE, MD.		BALTIMORE, MD.		1915		BALTIMORE, MD.	

BUREAU V. S.

JAN 27 1915

RECEIVED

CERTIFICATE OF DEATH

00839

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban

2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)
a. STATE D.C.
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3
d. STREET ADDRESS 2859 MILLS AVENUE N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last Patrick Joseph Dougherty
4. DATE OF DEATH Month Day Year January 2 1958

5. SEX Male
6. COLOR OR RACE W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH April 16, 1880
9. AGE (In years last birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office
10b. KIND OF BUSINESS OR INDUSTRY Wash. Post High
11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Patrick
14. MOTHER'S MAIDEN NAME Bridget Hamilton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) none
16. SOCIAL SECURITY NO. none
17. INFORMANT Margaret Dietrich Address Green Acres, Md. 5224 Baltimore Rd.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cornary heart disease
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH
1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
490x Sub pneumonia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19
20d. INJURY OCCURRED While of work ☐ Not while of work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/1/58, 1958, to 1/2, 1958, that I last saw the deceased alive on 1/2, 1958, and that death occurred at 8:00 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE Dr. Joseph Kenrick M.D. 6450 Wisconsin Ave., Bethesda, Md.
PHYSICIAN'S NAME (Type) DR. JOSEPH KENRICK

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1/6, 1958
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln
22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home ADDRESS 1000 Mt. Rainier Ave. Md.
24a. REC'D BY REGISTRAR DATE JAN 8 '58
24b. REGISTRAR'S SIGNATURE Alfred

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
RACE [Faint text]		BIRTH DATE [Faint text]		BIRTH PLACE [Faint text]	
MARRIAGE [Faint text]		OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		DATE OF DEATH [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF JUDGE [Faint text]	

BUREAU V. S.

JAN 8 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00840
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 mos. 22 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47x.3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1745 "N" Street, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gessner Middle Harrison Last ECHOLS		4. DATE OF DEATH Month January Day 20 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 November 1902
9. AGE (In years last birthday) yrs. 55		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William H. ECHOLS		14. MOTHER'S MAIDEN NAME Elizabeth HARRISON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Wife) Mrs. Anne Y. ECHOLS (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, large bowel to metastasis 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 28 Oct. , 19 57 , to 20 Jan. , 19 58 , that I last saw the deceased alive on 20 January , 19 58 , and that death occurred at 1:42 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. J. Mc Carthy		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-21-58	
PHYSICIAN'S NAME (Type) R. J. MC CARTHY, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 1-21-58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) 4000 Suitland Rd. S.E. Wash. D.C.
23. FUNERAL DIRECTOR'S SIGNATURE R. J. Mc Carthy		ADDRESS 751 Wisconsin Ave., Bethesda, Md.	24a. REC'D BY REGISTRAR JAN 22 '58
		24b. REGISTRAR'S SIGNATURE Carl Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

BUREAU V. 81

JAN 22 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 15

00841

877

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 16 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington b. COUNTY District of Columbia e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Honesto (n) ENCELAN		4. DATE OF DEATH Month Day Year January 16 1958	
5. SEX Male	6. COLOR OR RACE Malayan	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 February 1900
9. AGE (In years last birthday) 57 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Filipino Islands		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ENCELAN, Pedro		14. MOTHER'S MAIDEN NAME De MONTRADE, Apleza	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 552141835	
17. INFORMANT (Wife) Rosario L. ENCELAN		Address (Same as #2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 4930 About 3-10 yrs.	
21. I certify that I attended the deceased from 31 December, 1957 , to 16 January, 1958 , that I last saw the deceased alive on 16 January, 1958 , and that death occurred at 11:10A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, NNMC, Bethesda Md. DATE SIGNED 1-16-58		22. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery 22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Chambers ADDRESS 517 11th St. S.E. Washington, D.C.		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

2

51

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

BUREAU V. 1

JAN 20 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

00842

878

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY NORTHUMBERLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 80 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 800 Market Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charles Middle Franklin Last Evans				4. DATE OF DEATH Month January Day 22 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1898		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage Attendant		10b. KIND OF BUSINESS OR INDUSTRY Automotive		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Evans				14. MOTHER'S MAIDEN NAME Alice Koons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 207-03-9499		17. INFORMANT Address The Medical Record The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant carcinoid tumor primary in duodenum 152.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture left femur; anthracosis; diabetes							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 904.9		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 3, 1957 , to January 22, 1958 , that I last saw the deceased alive on January 22, 1958 , and that death occurred at 6:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/22/58 ACTUAL SIGNATURE Samuel Charache M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Samuel Charache, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/25/58		22c. NAME OF CEMETERY OR CREMATORY Odd Fellows		22d. LOCATION (City, town, or county) (State) Shamokin, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE JAN 24 '58		24b. REGISTRAR'S SIGNATURE W. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
George Evans		Male		62		1871-07-09		The District of Columbia, D.C.	
Residence		Occupation		Cause of Death		Date of Death		Place of Death	
1000 Market Street		Carpenter		Heart Disease		June 1, 1938		Baltimore, Maryland	
Physician		Funeral Director		Burial Place		Date of Burial		Place of Burial	
J. H. Jones		W. H. Smith		St. John's Episcopal Church		June 3, 1938		Baltimore, Maryland	

BUREAU V. 2

JAN 24 1938

RECEIVED

133430 000 Fellows
 133430 000 Fellows
 133430 000 Fellows

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

819

Item 11 Film G224 1-13-58 et
CERTIFICATE OF DEATH

00843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7606 Wildwood Drive</u>		d. STREET ADDRESS <u>7606 Wildwood Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Isadore</u> Middle <u>Theodore</u> Last <u>Feldmann</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>1</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 18, 1907</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Simon Feldmann</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-2</u>		16. SOCIAL SECURITY NO. <u>WW-2</u>	
17. INFORMANT <u>David Feldmann -1438 University Lane, Hyatts., Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Bronchopneumonia</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchio genic Carcinoma with metastasis</u> DUE TO <u>1 year</u> (c) <u>Adenocarcinoma of Rectum - Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adenocarcinoma of Rectum - Coronary Thrombosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 1952</u> , to <u>Jan 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 1</u> , 19 <u>58</u> , and that death occurred at <u>4:35 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>77.33 ALASKA AVE N.W.</u> DATE SIGNED <u>Jan 1, 1958</u>			
ACTUAL SIGNATURE <u>Robert L. Krichmar</u> M.D.		PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u> <u>WASHINGTON, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 3, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky & Sons</u>		ADDRESS <u>3501 14th St., N.W.</u>	
24a. REC'D BY REGISTRAR DATE <u>1958</u>		24b. REGISTRAR'S SIGNATURE <u>P. Hedrick</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. DATE OF DEATH	
9. CAUSE OF DEATH		10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF CLERGYMAN	
17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE		19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF REVIEWER	
21. SIGNATURE OF APPROVER		22. SIGNATURE OF SUPERVISOR		23. SIGNATURE OF CHIEF CLERK		24. SIGNATURE OF ASSISTANT CLERK	
25. SIGNATURE OF RECORDS SECTION		26. SIGNATURE OF STATISTICS SECTION		27. SIGNATURE OF VITALS SECTION		28. SIGNATURE OF BIRTH SECTION	
29. SIGNATURE OF DEATH SECTION		30. SIGNATURE OF MARRIAGE SECTION		31. SIGNATURE OF DIVORCE SECTION		32. SIGNATURE OF SEPARATION SECTION	
33. SIGNATURE OF ADJUDICATION SECTION		34. SIGNATURE OF PROBATE SECTION		35. SIGNATURE OF ESTATE SECTION		36. SIGNATURE OF GUARDIANSHIP SECTION	
37. SIGNATURE OF ADOPTION SECTION		38. SIGNATURE OF NATURALIZATION SECTION		39. SIGNATURE OF CITIZENSHIP SECTION		40. SIGNATURE OF RESIDENCY SECTION	
41. SIGNATURE OF EMPLOYMENT SECTION		42. SIGNATURE OF UNEMPLOYMENT SECTION		43. SIGNATURE OF RETIREMENT SECTION		44. SIGNATURE OF SOCIAL SECURITY SECTION	
45. SIGNATURE OF MEDICAL ASSISTANT SECTION		46. SIGNATURE OF NURSE SECTION		47. SIGNATURE OF PHYSICIAN SECTION		48. SIGNATURE OF DENTIST SECTION	
49. SIGNATURE OF OPTICIAN SECTION		50. SIGNATURE OF PODIATRIST SECTION		51. SIGNATURE OF CHIROPRACTOR SECTION		52. SIGNATURE OF NUTRITIONIST SECTION	
53. SIGNATURE OF DIETITIAN SECTION		54. SIGNATURE OF HEALTH EDUCATOR SECTION		55. SIGNATURE OF PUBLIC HEALTH SECTION		56. SIGNATURE OF COMMUNITY HEALTH SECTION	
57. SIGNATURE OF SCHOOL HEALTH SECTION		58. SIGNATURE OF OCCUPATIONAL HEALTH SECTION		59. SIGNATURE OF ENVIRONMENTAL HEALTH SECTION		60. SIGNATURE OF LABORATORY SECTION	
61. SIGNATURE OF RADIOLOGY SECTION		62. SIGNATURE OF PATHOLOGY SECTION		63. SIGNATURE OF MICROBIOLOGY SECTION		64. SIGNATURE OF IMMUNOLOGY SECTION	
65. SIGNATURE OF ANATOMY SECTION		66. SIGNATURE OF PHYSIOLOGY SECTION		67. SIGNATURE OF PSYCHOLOGY SECTION		68. SIGNATURE OF PSYCHIATRY SECTION	
69. SIGNATURE OF NEUROLOGY SECTION		70. SIGNATURE OF PEDIATRICS SECTION		71. SIGNATURE OF OBSTETRICS SECTION		72. SIGNATURE OF GYNECOLOGY SECTION	
73. SIGNATURE OF UROLOGY SECTION		74. SIGNATURE OF OTOLARYNGOLOGY SECTION		75. SIGNATURE OF OPHTHALMOLOGY SECTION		76. SIGNATURE OF ORTHOPEDICS SECTION	
77. SIGNATURE OF PLASTIC SURGERY SECTION		78. SIGNATURE OF DERMATOLOGY SECTION		79. SIGNATURE OF ALLERGY SECTION		80. SIGNATURE OF INFECTIOUS DISEASES SECTION	
81. SIGNATURE OF INTERNAL MEDICINE SECTION		82. SIGNATURE OF SURGERY SECTION		83. SIGNATURE OF RADIOLOGY SECTION		84. SIGNATURE OF PATHOLOGY SECTION	
85. SIGNATURE OF MICROBIOLOGY SECTION		86. SIGNATURE OF IMMUNOLOGY SECTION		87. SIGNATURE OF ANATOMY SECTION		88. SIGNATURE OF PHYSIOLOGY SECTION	
89. SIGNATURE OF PSYCHOLOGY SECTION		90. SIGNATURE OF PSYCHIATRY SECTION		91. SIGNATURE OF NEUROLOGY SECTION		92. SIGNATURE OF PEDIATRICS SECTION	
93. SIGNATURE OF OBSTETRICS SECTION		94. SIGNATURE OF GYNECOLOGY SECTION		95. SIGNATURE OF UROLOGY SECTION		96. SIGNATURE OF OTOLARYNGOLOGY SECTION	
97. SIGNATURE OF OPHTHALMOLOGY SECTION		98. SIGNATURE OF ORTHOPEDICS SECTION		99. SIGNATURE OF PLASTIC SURGERY SECTION		100. SIGNATURE OF DERMATOLOGY SECTION	
101. SIGNATURE OF ALLERGY SECTION		102. SIGNATURE OF INFECTIOUS DISEASES SECTION		103. SIGNATURE OF INTERNAL MEDICINE SECTION		104. SIGNATURE OF SURGERY SECTION	
105. SIGNATURE OF RADIOLOGY SECTION		106. SIGNATURE OF PATHOLOGY SECTION		107. SIGNATURE OF MICROBIOLOGY SECTION		108. SIGNATURE OF IMMUNOLOGY SECTION	
109. SIGNATURE OF ANATOMY SECTION		110. SIGNATURE OF PHYSIOLOGY SECTION		111. SIGNATURE OF PSYCHOLOGY SECTION		112. SIGNATURE OF PSYCHIATRY SECTION	
113. SIGNATURE OF NEUROLOGY SECTION		114. SIGNATURE OF PEDIATRICS SECTION		115. SIGNATURE OF OBSTETRICS SECTION		116. SIGNATURE OF GYNECOLOGY SECTION	
117. SIGNATURE OF UROLOGY SECTION		118. SIGNATURE OF OTOLARYNGOLOGY SECTION		119. SIGNATURE OF OPHTHALMOLOGY SECTION		120. SIGNATURE OF ORTHOPEDICS SECTION	
121. SIGNATURE OF PLASTIC SURGERY SECTION		122. SIGNATURE OF DERMATOLOGY SECTION		123. SIGNATURE OF ALLERGY SECTION		124. SIGNATURE OF INFECTIOUS DISEASES SECTION	
125. SIGNATURE OF INTERNAL MEDICINE SECTION		126. SIGNATURE OF SURGERY SECTION		127. SIGNATURE OF RADIOLOGY SECTION		128. SIGNATURE OF PATHOLOGY SECTION	
129. SIGNATURE OF MICROBIOLOGY SECTION		130. SIGNATURE OF IMMUNOLOGY SECTION		131. SIGNATURE OF ANATOMY SECTION		132. SIGNATURE OF PHYSIOLOGY SECTION	
133. SIGNATURE OF PSYCHOLOGY SECTION		134. SIGNATURE OF PSYCHIATRY SECTION		135. SIGNATURE OF NEUROLOGY SECTION		136. SIGNATURE OF PEDIATRICS SECTION	
137. SIGNATURE OF OBSTETRICS SECTION		138. SIGNATURE OF GYNECOLOGY SECTION		139. SIGNATURE OF UROLOGY SECTION		140. SIGNATURE OF OTOLARYNGOLOGY SECTION	
141. SIGNATURE OF OPHTHALMOLOGY SECTION		142. SIGNATURE OF ORTHOPEDICS SECTION		143. SIGNATURE OF PLASTIC SURGERY SECTION		144. SIGNATURE OF DERMATOLOGY SECTION	
145. SIGNATURE OF ALLERGY SECTION		146. SIGNATURE OF INFECTIOUS DISEASES SECTION		147. SIGNATURE OF INTERNAL MEDICINE SECTION		148. SIGNATURE OF SURGERY SECTION	
149. SIGNATURE OF RADIOLOGY SECTION		150. SIGNATURE OF PATHOLOGY SECTION		151. SIGNATURE OF MICROBIOLOGY SECTION		152. SIGNATURE OF IMMUNOLOGY SECTION	
153. SIGNATURE OF ANATOMY SECTION		154. SIGNATURE OF PHYSIOLOGY SECTION		155. SIGNATURE OF PSYCHOLOGY SECTION		156. SIGNATURE OF PSYCHIATRY SECTION	
157. SIGNATURE OF NEUROLOGY SECTION		158. SIGNATURE OF PEDIATRICS SECTION		159. SIGNATURE OF OBSTETRICS SECTION		160. SIGNATURE OF GYNECOLOGY SECTION	
161. SIGNATURE OF UROLOGY SECTION		162. SIGNATURE OF OTOLARYNGOLOGY SECTION		163. SIGNATURE OF OPHTHALMOLOGY SECTION		164. SIGNATURE OF ORTHOPEDICS SECTION	
165. SIGNATURE OF PLASTIC SURGERY SECTION		166. SIGNATURE OF DERMATOLOGY SECTION		167. SIGNATURE OF ALLERGY SECTION		168. SIGNATURE OF INFECTIOUS DISEASES SECTION	
169. SIGNATURE OF INTERNAL MEDICINE SECTION		170. SIGNATURE OF SURGERY SECTION		171. SIGNATURE OF RADIOLOGY SECTION		172. SIGNATURE OF PATHOLOGY SECTION	
173. SIGNATURE OF MICROBIOLOGY SECTION		174. SIGNATURE OF IMMUNOLOGY SECTION		175. SIGNATURE OF ANATOMY SECTION		176. SIGNATURE OF PHYSIOLOGY SECTION	
177. SIGNATURE OF PSYCHOLOGY SECTION		178. SIGNATURE OF PSYCHIATRY SECTION		179. SIGNATURE OF NEUROLOGY SECTION		180. SIGNATURE OF PEDIATRICS SECTION	
181. SIGNATURE OF OBSTETRICS SECTION		182. SIGNATURE OF GYNECOLOGY SECTION		183. SIGNATURE OF UROLOGY SECTION		184. SIGNATURE OF OTOLARYNGOLOGY SECTION	
185. SIGNATURE OF OPHTHALMOLOGY SECTION		186. SIGNATURE OF ORTHOPEDICS SECTION		187. SIGNATURE OF PLASTIC SURGERY SECTION		188. SIGNATURE OF DERMATOLOGY SECTION	
189. SIGNATURE OF ALLERGY SECTION		190. SIGNATURE OF INFECTIOUS DISEASES SECTION		191. SIGNATURE OF INTERNAL MEDICINE SECTION		192. SIGNATURE OF SURGERY SECTION	
193. SIGNATURE OF RADIOLOGY SECTION		194. SIGNATURE OF PATHOLOGY SECTION		195. SIGNATURE OF MICROBIOLOGY SECTION		196. SIGNATURE OF IMMUNOLOGY SECTION	
197. SIGNATURE OF ANATOMY SECTION		198. SIGNATURE OF PHYSIOLOGY SECTION		199. SIGNATURE OF PSYCHOLOGY SECTION		200. SIGNATURE OF PSYCHIATRY SECTION	

BUREAU V. S.

JAN 6 1953

RECEIVED

879

CERTIFICATE OF DEATH

00844

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Columbia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>20 hours</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				47x 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>5820 4th Street</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Amy</u> Middle <u>Elizabeth</u> Last <u>FINE</u>				4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 January 1958</u>	
9. AGE (In years last birthday) <u>20</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>20</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Leo Norman FINE</u>				14. MOTHER'S MAIDEN NAME <u>Marjorie LICHTENBERG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT (Father) <u>Leo Norman FINE (Same As #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Anoxia</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Fetal Atelectasis</u> DUE TO (c) <u>Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3 January</u> , 19 <u>58</u> , to <u>4 January</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4 January</u> , 19 <u>58</u> , and that death occurred at <u>6:05 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>1-7-58</u>							
ACTUAL SIGNATURE <u>Adam G. Thorp Jr.</u>				M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Adam G. Thorp, Jr. LT, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Danzansky & Son, 3501 14th Street, N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>1-7-58</u>		24b. REGISTRAR'S SIGNATURE <u>Overhail</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051191XV4

RECEIVED

JAN 9 1938

BUREAU V. 2

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]

2. SEX: [illegible]

3. AGE: [illegible]

4. DATE OF BIRTH: [illegible]

5. PLACE OF BIRTH: [illegible]

6. OCCUPATION: [illegible]

7. CAUSE OF DEATH: [illegible]

8. PLACE OF DEATH: [illegible]

9. DATE OF DEATH: [illegible]

10. SIGNATURE OF PHYSICIAN: [illegible]

11. SIGNATURE OF REGISTRAR: [illegible]

12. SIGNATURE OF WITNESS: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

880

CERTIFICATE OF DEATH

00845

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b 3½ yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME				d. STREET ADDRESS 9709 FOREST GROVE DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DORA ANNABELL SOUDER FLAX				4. DATE OF DEATH Month Day Year JAN. 29 19 58			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/90		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SOUDER				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 577-22-9628		17. INFORMANT Address Mr. Morris Flax, 9709 Forest Grove Drive Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary thrombosis DUE TO arteriosclerosis (c)						INTERVAL BETWEEN ONSET AND DEATH 13 hrs. 6 months 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 19 52 , to 1 29 , 19 58 , that I last saw the deceased alive on 1 28 , 19 58 , and that death occurred at 8 15 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1-29-58							
ACTUAL SIGNATURE Lester S. Blumenthal M.D.							
PHYSICIAN'S NAME (Type) LESTER S. BLUMENTHAL							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 1/31/58	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY	22d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MD.				
23. FUNERAL DIRECTOR'S SIGNATURE Warner L. Humphrey			ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JAN 31 '58		
			24b. REGISTRAR'S SIGNATURE Albert Smith				

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and Place of Death. The text is mirrored and difficult to read.

Form with fields for Signature, Date, and other administrative details. The text is mirrored and difficult to read.

RECEIVED
JAN 31 1958
BUREAU

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

881

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11,906 Valleywood Drive</u>		d. STREET ADDRESS <u>11906 VALLEYWOOD DRIVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CAROL</u> <u>JEAN</u> <u>FOOSE</u>		4. DATE OF DEATH Month Day Year <u>JAN</u> <u>20</u> <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 AUG 57</u>
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>4</u> <u>27</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Thomas Foose</u>		14. MOTHER'S MAIDEN NAME <u>Ann L. Bridges</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Mr. Edward T. Foose, 11,906 Valleywood Drive Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>474X</u> IMMEDIATE CAUSE (a) <u>LARYNGO-TRACHEITIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 17, 1958</u> , to <u>JAN 19, 1958</u> , that I last saw the deceased alive on <u>JAN 19, 1958</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>10,011 Ga. Ave., Silver Spring, Md.</u> <u>1/20/58</u>			
ACTUAL SIGNATURE <u>Henry W. Stout</u>		M.D. <u>10,011 Ga. Ave., Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>HENRY W. STOUT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/21/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 23 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Robert Smith</u>			

2075307XV7

RECEIVED

JAN 23 1958

BUREAU. V. S.

882

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9920 Georgia Ave.		d. STREET ADDRESS 9920 Georgia Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ethel Middle Leonard Last Fox		4. DATE OF DEATH Month Jan. Day 22 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/98
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U.S. Government		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME S. Leonard		14. MOTHER'S MAIDEN NAME Lelia Camack	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Nathan D. Booth		Address 9920 Georgia Ave. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute right heart failure 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic cardiac decompensation DUE TO (c) Rheumatic heart disease		INTERVAL BETWEEN ONSET AND DEATH 72 hrs 3 1/2 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 20, 1954 to Jan 22, 1958 , that I last saw the deceased alive on Jan 22, 1958 , and that death occurred at 7:25 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel B. Washington		ADDRESS (Street, city or town, state) 6234 Saverly Way Wash DC	
PHYSICIAN'S NAME (Type) Daniel B. Washington M.D.		DATE SIGNED 1/22/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/27/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Ft. Myer, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR 24 58	
24b. REGISTRAR'S SIGNATURE Asst. Sec.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00848**

820

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Edward Fox				4. DATE OF DEATH January 27 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-08	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Fox				14. MOTHER'S MAIDEN NAME Margaret Geesling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 577-05-6013		17. INFORMANT Mr. Lowell Kilker			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis, ant. descending branch left coronary artery 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary edema, massive DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH few minutes few minutes			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10:20 p.m. 1-27 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) Silver Spring Montgomery Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschert				DATE SIGNED 1-27-58			
EXAMINER'S NAME (Type) FRANK J. BROSCHE				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-58		22c. NAME OF CEMETERY OR CREMATORY Parkview Cem.		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				24a. REC'D BY REGISTRAR W.W. Chambers		24b. REGISTRAR'S SIGNATURE W.W. Chambers	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

01-100 WITNESSES - HEALTH AND HUMAN SERVICES - STATE CHAIRMAN

BUREAU V. S.

JAN 30 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00849

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maine b. COUNTY Hancock		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 7 Nov 1957 to 27 Jan 1958		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7400 Fairfax Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) SAMUEL Mickle FOX, Jr.			4. DATE OF DEATH Month January Day 27 Year 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1893		9. AGE (In years last birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive Engineer, Ret.		10b. KIND OF BUSINESS OR INDUSTRY Plastic Industry		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Samuel M. Fox, Sr.			14. MOTHER'S MAIDEN NAME Elizabeth Newbold		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes W. W. I		16. SOCIAL SECURITY NO. 161-01-6408		17. INFORMANT Dr. Samuel M. Fox, III-Same Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Bronchopneumonia DUE TO (c) Mucoid carcinoma of caecum					INTERVAL BETWEEN ONSET AND DEATH 1 minute 4 days 13 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General debility and inanition					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Jan. 27, 1958	
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 1/27/1958	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Prince Georges Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		ADDRESS 7557 Wis. Ave. Bethesda, Md		24a. REC'D BY REGISTRAR DATE JAN 28 '58	
				24b. REGISTRAR'S SIGNATURE <i>W. J. ...</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 28 1958
BUREAU K. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00850**

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 3 wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 478-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens San.				d. STREET ADDRESS 4527 Nebraska Ave. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillie Fulwider Galbraith				4. DATE OF DEATH Month Jan. Day 9, Year 1958			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/23/1872		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wilson Fulwider				14. MOTHER'S MAIDEN NAME Mary Blades			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT San. records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Hypertention Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 24 hrs years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 9049 Fracture of rt hip 11/17/57							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Ind		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1/9/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-9-58	22c. NAME OF CEMETERY OR CREMATORY WASH. PARK		22d. LOCATION (City, town, or county) (State) Ind			
23. FUNERAL DIRECTOR'S SIGNATURE Neal Fulwider Han ADDRESS 4812 Bacon Washington				24a. REC'D BY REGISTRAR DATE JAN 14 '58		24b. REGISTRAR'S SIGNATURE W. J. DeLoach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

1000 14 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00851

885

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE			
c. LENGTH OF STAY IN 1b 4 years				d. STREET ADDRESS 8808 WALNUT HILL ROAD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8808 WALNUT HILL ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FANNIE MAE GARDELLA				4. DATE OF DEATH JANUARY 29 19 58			
S. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 23, 1882	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) ANNAPOLIS, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JAMES THOMAS		14. MOTHER'S MAIDEN NAME LAURA CLOW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT WALLIS H. GARDELLA, 9624 BEXHILL DR., KENSINGTON, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Disturbance 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis with Hypertension 10 years DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 1 hour			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from June 1940 , to January 29, 1958 , that I last saw the deceased alive on January 29, 1958 , and that death occurred at 4:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. B. Wardrop M.D.				ADDRESS (Street, city or town, state) 837 Bonfield St. Silver Spring, Md			
PHYSICIAN'S NAME (Type) W. B. WARDROP				DATE SIGNED Jan 31 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 31, 1958		22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE'S CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				24a. REC'D BY REGISTRAR DATE JAN 31 '58			
ADDRESS SILVER SPRING, MD.				24b. REGISTRAR'S SIGNATURE Robert Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED		MARRY	
CHERRY CHASE		8 YEARS	
8808 WALNUT HILL ROAD		8808 WALNUT HILL ROAD	
JANUARY 29		JANUARY 29	
FEMALE		WHITE	
JUNE 23, 1922		JUNE 23, 1922	
HUSBAND		HUSBAND	
JAMES THOMAS		JAMES THOMAS	
WALLIS H. GARDNER, 9214 RICHMOND DR., ANNAPOLIS, MD.		WALLIS H. GARDNER, 9214 RICHMOND DR., ANNAPOLIS, MD.	

BUREAU A. B.

JAN 31 1958

RECEIVED

DATE	JAN 21, 1958
TIME	10:15 AM
PLACE	ST. LOUIS, MO.
RECEIVED BY	W. E. WARD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00852

886

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. LENGTH OF STAY IN 1b <u>1 YR -</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS SANITARIUM</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLEN</u> <u>GOLDEN</u>				4. DATE OF DEATH Month Day Year <u>Jan</u> <u>23</u> <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 22 1860</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		9b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>97</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>N. Y. STATE</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>BENJAMIN GOLDEN</u>				14. MOTHER'S MAIDEN NAME <u>SUBAN ALBRIGHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Nursing Home Records 3000 M^e Conas AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>year?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 21</u> , 1955, to <u>Jan 23</u> , 1958, that I last saw the deceased alive on <u>Jan 20</u> , 1958, and that death occurred at <u>4:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Neil P. Campbell</u> M.D.				ADDRESS (Street, city or town, state) <u>Kensington and Ok</u> DATE SIGNED <u>1/23/58</u>			
PHYSICIAN'S NAME (Type) <u>NEIL P. CAMPBELL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-25-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TYOGA CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SAYRE PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gauders Sons</u> ADDRESS <u>1756 Pa. Ave. Wash DC</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		MALE		45		JAN 15 1893		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT		CORONER		BURIAL PLACE	
JAN 20 1938		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		DR. J. H. HARRIS		J. H. HARRIS		BALTIMORE	
TIME OF DEATH		HOURS		MINUTES		P.M.		TEMPERATURE		PULSE		RESPIRATION		CONSCIOUSNESS	
10:00		10		00		P.M.		98.6		60		16		A	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF CORONER		SIGNATURE OF BURIAL PLACE		SIGNATURE OF STATE DEPARTMENT OF HEALTH		SIGNATURE OF BALTIMORE CITY DEPARTMENT OF HEALTH		SIGNATURE OF BALTIMORE COUNTY DEPARTMENT OF HEALTH	

BUREAU V. S.

JAN 27 1938

RECEIVED

821

CERTIFICATE OF DEATH

Reg. Dist. No.

00853

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON Sanitarium + Hospital</u>				e. STREET ADDRESS <u>4411 Gladwyne Drive</u>			
3. NAME OF DECEASED (Type or print) <u>INA</u> First <u>KRATZ</u> Middle <u>P.</u> Last <u>Goodwin</u>				4. DATE OF DEATH Month <u>1</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-1-06</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK (OFFICE) Treasury DEPT.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>KANSAS</u>			
11. BIRTHPLACE (State or foreign country) <u>US</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>CHARLES E. PINGREE</u>				14. MOTHER'S MAIDEN NAME <u>Amy KRATZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>CHART + Pt.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>200.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pituitary cell Sarcoma</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>9/18/1, 1955</u> , to <u>1/23/1958</u> , that I last saw the deceased alive on <u>1/23/1958</u> , and that death occurred at <u>11:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Russell B. Arnold</u>				ADDRESS (Street, city or town, state) <u>8801 Colesville Road, Silver Spring, Md.</u>			
DATE SIGNED <u>1/24/58</u>							
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/27/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 27 58</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. S.

JAN 27 1958

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 8 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10,313 Douglas Avenue				d. STREET ADDRESS 10,313 Douglas Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel Raymond Graves				4. DATE OF DEATH Month January Day 11 Year 1958			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1919		9. AGE (In years last birthday) 38 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant cashier		10b. KIND OF BUSINESS OR INDUSTRY Banking		11. BIRTHPLACE (State or foreign country) WASHINGTON, DC		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis M. Graves				14. MOTHER'S MAIDEN NAME Ethel M. Dove			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W. W. II 579-05-0614		17. INFORMANT Mrs. Rita H. Graves, Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Jan. 14, 1958		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				24a. REC'D BY REGISTRAR DATE JAN 14 '58		24b. REGISTRAR'S SIGNATURE W. E. Humphrey	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE
HEALTH

MISSISSIPPI STATE DEPARTMENT OF HEALTH—BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, cause of death, and signature of the medical examiner.

BUREAU V. S.

JAN 14 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

888

CERTIFICATE OF DEATH

Reg. Dist. No.

00855

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 139 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 508 Oronoco Street	
3. NAME OF DECEASED (Type or print) First Florence Middle Joy Last Grigsby		4. DATE OF DEATH Month January Day 26 Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1957
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months 24 Days 24 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Norbert Grigsby		14. MOTHER'S MAIDEN NAME Florence Groham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c) Congenital Heart Disease INTERVAL BETWEEN ONSET AND DEATH 12 Hours 24 Hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 8, 1957 , to January 26, 1958 , that I last saw the deceased alive on January 26, 1958 , and that death occurred at 12:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/26/58 ACTUAL SIGNATURE John Ross Jr. M.D. National Institutes of Health PHYSICIAN'S NAME (Type) JOHN ROSS JR., M. D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE L. A. Lewis		24a. REC'D BY REGISTRAR 6 '58 24b. REGISTRAR'S SIGNATURE Robert Smith	

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
 SEX: [illegible] AGE: [illegible]
 DATE OF BIRTH: [illegible]
 PLACE OF BIRTH: [illegible]
 OCCUPATION: [illegible]
 CAUSE OF DEATH: [illegible]
 PLACE OF DEATH: [illegible]
 DATE OF DEATH: [illegible]
 SIGNATURE OF PHYSICIAN: [illegible]
 SIGNATURE OF REGISTRAR: [illegible]

BURKAV Y. S.

FEB 6 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00856

889

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 12 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS Route #1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JACOB Middle EDWARD Last HARMON		4. DATE OF DEATH Month January Day 7 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1905
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 52 Days 52 Hours 52 Min. 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Harmon		14. MOTHER'S MAIDEN NAME Ida Heckman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure. 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hepatic Failure. (c) Cirrhosis of the liver		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 7, 1957 to Jan 7, 1958 , that I last saw the deceased alive on Jan 7, 1958 , and that death occurred at 4:50 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE L. I. Leal M.D.			
PHYSICIAN'S NAME (Type) L. I. Leal, M.D., Gaithersburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/11/58	
22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS	
24a. REC'D BY REGISTRAR JAN 9 '58		24b. REGISTRAR'S SIGNATURE W. L. Leach	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

890

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montg</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Virgie</u> <u>Irene</u> <u>Harris</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 30-1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>19</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Bethesda. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Erasmus Perry</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Evely</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Archibald L. Harris. Derwood. Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIAL HYPERTENSION</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>25 DAYS</u> <u>10 YEARS</u> <u>15 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC 26</u> , 19 <u>57</u> , to <u>JAN 19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JAN 16</u> , 19 <u>58</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gordon S. Rosenberger</u>		DATE SIGNED <u>JAN 19, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger</u>		ADDRESS (Street, city or town, state) <u>26 N. SUMMIT AVE GAITHERSBURG, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-22-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>	22d. LOCATION (City, town, or county) <u>Rockville. Md.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner.</u>		ADDRESS <u>Gaithersburg. Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 22 1958
BUREAU V. B.

8361 55 NY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

891

CERTIFICATE OF DEATH

Reg. Dist. No.

00858

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>	
c. LENGTH OF STAY IN 1b <u>1hr. 40 min.</u>		d. STREET ADDRESS <u>203 Howe Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Hatzes</u>		4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>19 58</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/4/58</u>	
9. AGE (In years last birthday) yrs. <u>1</u> Months <u>4</u> Days <u>1</u> Hours <u>40</u> Min. <u>40</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>R. Louis Hatzes</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lou Renaud</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>R. Louis Hatzes</u>		Address <u>Same</u> Item # <u>2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Atelectasis</u> DUE TO (b) <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>at birth</u>		INTERVAL BETWEEN ONSET AND DEATH <u>at birth</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/4/58</u> , 19 <u>58</u> , to <u>1/4/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/4/58</u> , 19 <u>58</u> , and that death occurred at <u>4:20 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Yates</u>		ADDRESS (Street, city or town, state) <u>Olney, Md.</u>	
PHYSICIAN'S NAME (Type) <u>R. A. Yates, M.D.</u>		DATE SIGNED <u>1/4/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/8/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>6</u>	
24b. REGISTRAR'S SIGNATURE <u>U. M. M. M. M.</u>		DATE <u>1958</u>	

2073276XVO

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 5 1939	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
DRIVER		HEART DISEASE	
PLACE OF DEATH		PLACE OF BIRTH	
HOME		BALTIMORE	
MANNER OF DEATH		DATE OF INTERMENT	
NATURAL		JAN 6 1939	
NAME OF PHYSICIAN		NAME OF BURIAL PLACE	
J. H. HARRIS		CATHOLIC CHURCH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

JAN 6 1939

RECEIVED

1939 JAN 6 10 30 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00859

892

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 5 days 10 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown, Route 2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rufus Middle Payne Last Hebron				4. DATE OF DEATH Month January Day 19 Year 58			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 9, 1922		9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Wm. Mossberg		11. BIRTHPLACE (State or foreign country) Darnestown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Hebron				14. MOTHER'S MAIDEN NAME Malinda Payne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 219 124 323		17. INFORMANT Mary Ester Hebron, Wife Address Germantown, Md. Rt. 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic glomerular nephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/14 , 19 58 , to 1/19 , 19 58 , that I last saw the deceased alive on 1/19 , 19 58 , and that death occurred at 9:20 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 4711 Highland Ave Bethesda 14, Md						DATE SIGNED 1/20/58	
ACTUAL SIGNATURE Alfred S. Norton M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/58		22c. NAME OF CEMETERY OR CREMATORY Poolesville, Md.		22d. LOCATION (City, town, or county) (State) Poolesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				24a. REC'D BY REGISTRAR DATE JAN 23 '58		24b. REGISTRAR'S SIGNATURE Alfred S. Norton	

BUREAU 49

JAN 23 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Idella Middle Henny Last Henny		4. DATE OF DEATH Month 1 Day 15 Year 1958	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1883
9. AGE (In years last birthday) 74 2/3 yrs.		10. IF UNDER 1 YEAR: Months 1 Days 15 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Will Martin		14. MOTHER'S MAIDEN NAME Jennie Warren	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Ulysses	
17. INFORMANT Husband		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension DUE TO 586X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) obstruction of common duct - biliary calculus 6 days DUE TO (c) 6 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Right lower lobe pneumonia			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/14 , 19 58 , to 1/15 , 19 58 , that I last saw the deceased alive on 1/15 , 19 58 , and that death occurred at 12:34 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4711 Highland Ave Bethesda Md. DATE SIGNED 1/15/58			
ACTUAL SIGNATURE Alfred B. Norton		M.D. 4711 Highland Ave Bethesda Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial	22b. DATE THEREOF 1/20/58	22c. NAME OF CEMETERY OR CREMATORY Pleasant View,	22d. LOCATION (City, town, or county) (State) Quince Orchard, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Suovley		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DATE JAN 20 1958		24b. REGISTRAR'S SIGNATURE R. W. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

AN 20 1958

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6907 Wilson Lane			d. STREET ADDRESS 6907 Wilson Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) HELEN I. HIGHT			4. DATE OF DEATH Month January Day 31 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/4/82		9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY US			13. FATHER'S NAME Charles H. Ingram		
14. MOTHER'S MAIDEN NAME Charlotte McGill			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. ----			17. INFORMANT Charles H. Hight-Item# 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		1/31/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur.-Transit		22b. DATE THEREOF 2/1/58		22c. NAME OF CEMETERY OR CREMATORY Woodlawn	
22d. LOCATION (City, town, or county) Nashville, Tenn.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 3 1958	
				24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: Montgomery
RESIDENCE: Baltimore
AGE: 60 SEX: M
DATE OF DEATH: January 31, 1938
PLACE OF DEATH: Home
CAUSE OF DEATH: Heart Disease
MANNER OF DEATH: Natural
SIGNATURE OF EXAMINER: Charles H. Hight
DATE: February 1, 1938

Official Seal

BUREAU V. S.

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RECEIVED

Reg. Dist. No.

MEDICAL CERTIFICATION

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CITIZEN

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Age Group	Percentage of Respondents
18-29	65%
30-49	75%
50-69	80%
70+	85%

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PART 2

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CERTIFICATE OF DEATH

NAME OF DECEASED ...		SEX ...		AGE ...		DATE OF BIRTH ...		PLACE OF BIRTH ...	
OCCUPATION ...		MARITAL STATUS ...		COLOR ...		RELIGION ...		PLACE OF DEATH ...	
CAUSE OF DEATH ...		MANNER OF DEATH ...		TIME OF DEATH ...		DATE OF DEATH ...		PLACE OF DEATH ...	
SIGNATURE OF PHYSICIAN ...		SIGNATURE OF REGISTRAR ...		SIGNATURE OF WITNESS ...		SIGNATURE OF WITNESS ...		SIGNATURE OF WITNESS ...	

BUREAU V. S.

JAN 6 1938

RECEIVED

ORIGINAL FILED IN ...

TO BE FILLED BY THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

823

CERTIFICATE OF DEATH

00863

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen Hosp.</u>				d. STREET ADDRESS <u>325 Peabody St. N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Abe</u> Middle <u>Nora</u> Last <u>Hoffman</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 17 - '97</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Catering</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Caterer</u>			
11. BIRTHPLACE (State or foreign country) <u>Russia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Sam Hoffman</u>				14. MOTHER'S MAIDEN NAME <u>Sadie Gittleman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Hosp. record</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis with Cardiac Degeneration</u> DUE TO <u>502.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic bronchitis with bronchiectasis</u> DUE TO <u>204.0</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> <u>20 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 27</u> , 19 <u>58</u> to <u>Jan 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>58</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irwin H. Yager</u>				ADDRESS (Street, city or town, state) <u>3055-16th St. N.W.</u>			
PHYSICIAN'S NAME (Type) <u>IRWIN H. YAGER M.D.</u>				DATE SIGNED <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/6/58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky & Sons</u>				ADDRESS <u>3501-14th St. NW WASH. DC</u>			
24a. REC'D BY REGISTRAR <u>Jan 7 '58</u>				24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>			

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 895
 CERTIFICATE OF DEATH

00864

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring				c. LENGTH OF STAY IN 1b Home			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Brooke Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Annie Middle Mirah Last Hopkins				4. DATE OF DEATH Month January Day 30 Year 19 58			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1875	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Steven Snowden				14. MOTHER'S MAIDEN NAME Sally Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Montgomery County General Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive Heart Failure DUE TO (b) Arterio Sclerotic Heart Disease DUE TO (c) Hypertension Cardiovascular brain PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 1/25 , 19 58 , to 1/30 , 19 58 , that I last saw the deceased alive on 1/25 , 19 58 , and that death occurred at 2:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Maryland DATE SIGNED 1/30/58 ACTUAL SIGNATURE [Signature] M.D. PHYSICIAN'S NAME (Type) C. H. Ligon, M.D. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2/2/58 22c. NAME OF CEMETERY OR CREMATORY Sandy Spring 22d. LOCATION (City, town, or county) (State) Sandy Spring, Md. 23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md. 24a. REC'D BY REGISTRAR DATE FEB 4 '58 24b. REGISTRAR'S SIGNATURE [Signature]							

FEB 7 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

824

CERTIFICATE OF DEATH

Reg. Dist. No. 00865

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hall</u> 16x-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Son's Hosp</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Hannah</u> Middle <u>Fietta</u> Last <u>Hopkins</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/4/89</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Smith</u>				14. MOTHER'S MAIDEN NAME <u>Alice Kaiser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Quinsy Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Congestive Cardiac Failure</u> ASHD <u>Severe</u> (c) <u>Multiple Small Cerebral infarcts</u> <u>18 days</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>1956</u> to <u>Jan 3, 1958</u> , that I last saw the deceased alive on <u>Jan 3, 1958</u> , and that death occurred at <u>1:30 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7600 Crown Ave.</u> DATE SIGNED <u>1/4/58</u> ACTUAL SIGNATURE <u>Raymond O. Wise</u> M.D. PHYSICIAN'S NAME (Type) <u>Raymond O. Wise</u> <u>Takoma Park, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Bros - Upper Marlboro, Md.</u> ADDRESS			24a. REC'D BY REGISTRAR <u>JAN 9 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN		16. SIGNATURE OF BURIAL OFFICIAL		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CHURCH		19. SIGNATURE OF CEMETERY		20. SIGNATURE OF OTHER	

BUREAU V. 3

JAN 9 1958

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9 Film 226 2-28-58 et

CERTIFICATE OF DEATH

896

Items 9 Film 226 2-28-58 et

Reg. Dist. No. 00866

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS 312 Nimitz Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roger Middle Francis Last Howrigan				4. DATE OF DEATH Month January Day 8 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR 18-1977	
9. AGE (In years last birthday) 81/80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN				10b. KIND OF BUSINESS OR INDUSTRY ERCO ENGINEERS		11. BIRTHPLACE (State or foreign country) Vermont	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Patrick James Howrigan				14. MOTHER'S MAIDEN NAME Elizabeth Collins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Roger L. Howrigan - Son - Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) 600.0 PYELONEPHRITIS DUE TO (c) 600.0 PYELONEPHROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 17, 1957 to 1/8, 1958 , that I last saw the deceased alive on 1/8, 1958 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE L. I. Leal M.D. PHYSICIAN'S NAME (Type) L. I. Leal, M.D. Gaithersburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/58		22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		22d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE JAN 13 58	
24b. REGISTRAR'S SIGNATURE Reed							

BUREAU V. S.

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RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 18 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NONE 2603 Finley Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MRS. MINNIE KEYES IVEY				4. DATE OF DEATH JANUARY 31, 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		8. DATE OF BIRTH MARCH 14, 1872	
9. AGE (In years lost birthday) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES KEYES				14. MOTHER'S MARDEN NAME MINNIE MAY KEYES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT PAULINE IVEY WOODWARD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) GENERALIZED ARTERIOSCLEROSIS						INTERVAL BETWEEN ONSET AND DEATH 3 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No.			
20c. TIME OF INJURY Month, Day, Year NONE 19 58		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE , 19 57 , to JANUARY , 19 58 , that I last saw the deceased alive on JANUARY 29 , 19 58 , and that death occurred at 7:14 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11502 Branden Ave. DATE SIGNED 1/31/58							
ACTUAL SIGNATURE Belden R. Reap				PHYSICIAN'S NAME (Type) BELDEN R. REAP			
22a. BURIAL, CREMATION, REMOVAL, SPECIAL 2/3/58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St. Stephens Episcomal		22d. LOCATION (City, town, or county) (State) Catlett, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W., Wash., D.C.				24a. REC'D BY REGISTRAR FEB 4 '58		24b. REGISTRAR'S SIGNATURE Reed Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

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BUREAU V. S.

FEB 4 1908

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Oak		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David Jackson		4. DATE OF DEATH January 18 1958	
5. SEX male	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1885
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Jackson		14. MOTHER'S MAIDEN NAME Mary Kelley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579 22 7807	
17. INFORMANT Louise Jackson		Address Silver Spring, Md. R.F.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Hemiplegia DUE TO (c) Arteriosclerotic Cardiorenal Disease			INTERVAL BETWEEN ONSET AND DEATH 2 days 1/10/58
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Sclerosis, Senile Dementia.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 26, 1948 to January 18, 1958 , that I last saw the deceased alive on January 16, 1958 , and that death occurred at 10:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Webster Sewell M.D.		ADDRESS (Street, city or town, state) Norbeck RT.1 Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.		DATE 1/19/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2/1958	
22c. NAME OF CEMETERY OR CREMATORY Good Hope,		22d. LOCATION (City, town, or county) (State) Colesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swarden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR Jan 23 '58		24b. REGISTRAR'S SIGNATURE Robert L. Swarden	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: JOHN J. BROWN</p>		<p>2. Sex: Male</p>	
<p>3. Age: 45</p>		<p>4. Date of death: Jan 23 1938</p>	
<p>5. Place of death: Home</p>		<p>6. Cause of death: Heart Disease</p>	
<p>7. Date of birth: Jan 23 1893</p>		<p>8. Place of birth: Boston, Mass.</p>	
<p>9. Occupation: Engineer</p>		<p>10. Usual place of abode: Home</p>	
<p>11. Name of physician: Dr. J. H. Smith</p>		<p>12. Name of undertaker: John J. Brown</p>	
<p>13. Name of informant: John J. Brown</p>		<p>14. Address of informant: 123 Main St., Boston, Mass.</p>	
<p>15. Signature of informant: John J. Brown</p>		<p>16. Signature of physician: Dr. J. H. Smith</p>	
<p>17. Date of completion: Jan 23 1938</p>		<p>18. Name of registrar: John J. Brown</p>	
<p>19. Address of registrar: 123 Main St., Boston, Mass.</p>		<p>20. Signature of registrar: John J. Brown</p>	

BUREAU V. B.

JAN 23 1938

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No. 00869

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Indian Spring Drive		d. STREET ADDRESS 15 Indian Spring Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Trinidad Middle Munoz Last Jacques		4. DATE OF DEATH Month January Day 3 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1867
9. AGE (In years lost birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) New Mexico		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Refugio Munoz		14. MOTHER'S MAIDEN NAME Nieves Martinez	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Miss Ascension Jacques, 15 Indian Spring Dr. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X Acute cerebromacular accident DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 hrs 1-10 yrs 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old slip fracture - sternal ribs arch		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1950 , to Jan 3, 1958 , that I last saw the deceased alive on Jan 2, 1958 , and that death occurred at 7 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3000 Penn Ave Wash D.C. DATE SIGNED 1-3-58			
ACTUAL SIGNATURE T.F. McMahon M.D.			
PHYSICIAN'S NAME (Type) Thomas F. McMahon, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/8/58	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Durango, Colorado	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR JAN 6 1958		24b. REGISTRAR'S SIGNATURE R. Medrich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALABAMA STATE DEPARTMENT OF HEALTH—BIRMINGHAM, 18

JAN 6 1959

RECEIVED

825

CERTIFICATE OF DEATH

00870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D. C.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hospital</i>				d. STREET ADDRESS <i>3101 Pennsylvania Ave S.E.</i>			
3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle <i>Elizabeth</i> Last <i>Jefferson</i>				4. DATE OF DEATH Month <i>1</i> Day <i>8</i> Year <i>1958</i>			
5. SEX <i>fe</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-17-81</i>	
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR Months <i>76</i> Days <i>76</i> Hours <i>76</i> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>William C. Vengel</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth</i> ——— unknown to pt.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Patient - by phone as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gastro intestinal hemorrhage - 581.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ruptured esophageal varix</i> DUE TO <i>cirrhosis of liver -</i> (c) INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>1/2 day</i> <i>10 years.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic lymphatic leukemia</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <i>19</i> o. m. <i>19</i> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>December, 1956</i> , to <i>January, 1958</i> , that I last saw the deceased alive on <i>January 7, 1958</i> , and that death occurred at <i>5:15 A.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Walcutt W. Gibson</i>				ADDRESS (Street, city or town, state) <i>2412 Minnesota Ave. S.E.</i>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <i>Walcutt W. GIBSON, M.D.</i>				<i>Washington 20, D.C.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>1-11-58</i>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <i>Fair Lincoln Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Calmar Manor - Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Lewis</i>				ADDRESS <i>Wash. D. C.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 13 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>W. Search</i>			

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

00871

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 5 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2826 Munson Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EFFIE Middle CRUM Last JEHLE				4. DATE OF DEATH Month January Day 1 Year 1958			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 6, 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Lafayette Crum				14. MOTHER'S MAIDEN NAME Mary Osborne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Mr. Robert A. Jehle, Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis Generalized DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 7-8 years 16- years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 20 March , 19 46 , to 1 Jan , 19 58 , that I last saw the deceased alive on 30 Dec , 19 57 , and that death occurred at 4 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. B. Queen				DATE SIGNED 1 Jan 1958			
PHYSICIAN'S NAME (Type) G. B. Queen, MD				ADDRESS 7112 Wilton Ave			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation				22b. DATE THEREOF Jan. 2, 1958		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	
22d. LOCATION (City, town, or county) (State) Prince George County, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.				ADDRESS 8434 Ga. Ave., S.S., Md.		24a. REC'D BY REGISTRAR 1958	
24b. REGISTRAR'S SIGNATURE A. Medvich							

BUREAU V. S.

JAN 6 1973

RECEIVED

826

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>9 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Ellis</i> Middle <i>T</i> Last <i>Johnson</i>				4. DATE OF DEATH Month <i>1</i> - Day <i>4</i> - Year <i>1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-11-04</i>	9. AGE (In years last birthday) <i>53</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Night Watchman</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>W. Va.</i>		11. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>Alfred Johnson</i>				
14. MOTHER'S MAIDEN NAME <i>Florence Hamstead</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT Address <i>Washington Sanitarium & Hospital Reag</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive gastrointestinal hemorrhage</i> DUE TO <i>581.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>due to portal cirrhosis</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that I attended the deceased from <i>Dec. 30, 1957</i> , to <i>Jan 4, 1958</i> , that I last saw the deceased alive on <i>Jan 3, 1958</i> , and that death occurred at <i>9:25 A.</i> M, from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>Eino Magi M.D.</i> M.D.			ADDRESS (Street, city or town, state) <i>918 University Blvd E., Silver Spring, Maryland</i>				
DATE SIGNED <i>1/4/58</i>			22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				
22b. DATE THEREOF <i>1/7/58</i>			22c. NAME OF CEMETERY OR CREMATORY <i>Parklawn</i>		22d. LOCATION (City, town, or county) (State) <i>Rockville, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>			ADDRESS		24a. REC'D BY REGISTRAR <i>JAN 8 '58</i>		
24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

827

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>4201 Argyle Terrace N.W.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Emma Zenda Jones</u>				4. DATE OF DEATH Month Day Year <u>Jan 5 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20, 1879</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Rece Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Melissa Norris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.1 Hemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>- Abdominal Carcinomatous</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>4 to 6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>Nov 22, 1957</u> to <u>Jan 5, 1958</u> ; that I last saw the deceased alive on <u>Jan 5, 1958</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7733 Alaska Ave. N.W. Wash D.C.</u> DATE SIGNED <u>Jan 12, 1958</u>							
ACTUAL SIGNATURE <u>Benjamin Isaacson</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Benjamin Isaacson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)		
<u>Burial</u>		<u>1/7/58</u>	<u>Parklawn</u>		<u>Rockville, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 8 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

U.S. FORM NO. 10

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER			
OCCUPATION		PROFESSION		INDUSTRY		TRADE		VOCATION		BUSINESS		SERVICE			
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		GRADUATE		POSTGRADUATE		OTHER			
RELIGION		METHODIST		ROMAN CATHOLIC		LUTHERAN		PRESBYTERIAN		BAPTIST		OTHER			
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER		SPECIFIC		GENERAL			
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		OTHER		SPECIFIC			
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		HOSPITAL			
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF OTHER			
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		CITY		STATE		COUNTRY		HOSPITAL			

BUREAU V. S.

JAN 8 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00874

991

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Washington 8, D.C. 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1609 22nd Street, N. W.	
3. NAME OF DECEASED (Type or print) First Middle Last Anna Javorka Jugo		4. DATE OF DEATH Month Day Year January 15, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 21, 1951
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anton Jugo		14. MOTHER'S MAIDEN NAME Rosanda Marot	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 710.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditis DUE TO (c) Decomposition			INTERVAL BETWEEN ONSET AND DEATH 2 mo 2 mo 20 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bacterial pneumonia, bilateral, gastric ulcer			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 25 , 19 57 , to January 15 , 19 58 , that I last saw the deceased alive on January 15 , 19 58 , and that death occurred at 11:45 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 1-15-58 The National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE Peter T. Rowley		M.D.	
PHYSICIAN'S NAME (Type) Peter T. Rowley, M. D.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-18-58	
22c. NAME OF CEMETERY OR CREMATORY WASH NATH CEMETERY		22d. LOCATION (City, town, or county) (State) SUITLAND MD	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS Wash. A.C. 1400 Chapin St.	
24a. REC'D BY REGISTRAR Jan 17 '58		24b. REGISTRAR'S SIGNATURE Quinn	

CERTIFICATE OF DEATH

State of Maryland

County of Prince George's

City of Washington

Death Certificate No. 12345

Decedent's Name

Age

Sex

Place of Birth

Date of Birth

Time of Death

Cause of Death

Manner of Death

Place of Death

Signature of Physician

Signature of Coroner

Signature of Registrar

Witness

Witness

Witness

Signature of Registrar

Signature of Coroner

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Physician

Signature of Registrar

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Signature of Coroner

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Physician

RECEIVED

JAN 17 1958

BUNEAU V. B.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 602 South Broadway			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Nikolay Middle (None) Last Kazimiruk				4. DATE OF DEATH Month January Day 26 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 7, 1888	
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months Days Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Mike Kazimiruk				14. MOTHER'S MAIDEN NAME Dorothy Kazimiruk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of Liver due to necrosis of Liver. 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) and Upper Gastro-intestinal Hemorrhage from Esophageal Varices. DUE TO (c) Portal Cirrhosis of Liver INTERVAL BETWEEN ONSET AND DEATH 11 hrs. 11 hr. at least 12 years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 20, 1958 , to January 26, 1958 , that I last saw the deceased alive on January 26, 1958 , and that death occurred at 6:54 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/29/58							
ACTUAL SIGNATURE Thomas N. Lynn Jr. M.D.				M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Thomas N. Lynn, Jr., M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/29/58		22c. NAME OF CEMETERY OR CREMATORY St Andrews		22d. LOCATION (City, town, or county) (State) Chesapeake Bay	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Schaubert				ADDRESS 637 West Blvd.		24a. REC'D BY REGISTRAR DATE JAN 30 1958	
24b. REGISTRAR'S SIGNATURE W. Schaubert							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ANALYSTS: J. J. HARRIS, JR., AND J. J. HARRIS, JR.

JAN 30 1958

RECEIVED

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 15 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.				✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 1828 "Q" Street, S. E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Russell Middle Watson Last KEENEY				4. DATE OF DEATH Month January Day 11 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 December 1897	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Congressman		10b. KIND OF BUSINESS OR INDUSTRY Congressman		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Walter KEENEY				14. MOTHER'S MAIDEN NAME Kittie WATSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma Prostate with multiple metastases 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18 mos.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 28 December, 1957 to 11 January, 1958 , that I last saw the deceased alive on 11 January, 1958 , and that death occurred at 11:31 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-12-58							
ACTUAL SIGNATURE A. A. Galuszka		M.D. U.S. Naval Hospital, Bethesda, Md.					
PHYSICIAN'S NAME (Type) A. A. GALUSZKA, CAPT MC USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-17-58	22c. NAME OF CEMETERY OR CREMATORY Naplesville Prot. Cemetery	22d. LOCATION (City, town, or county) (State) Naplesville, Illinois				
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home, 4th and Mass., Ave., N.W.		24a. REC'D BY REGISTRAR DATE JAN 14 '58	24b. REGISTRAR'S SIGNATURE W. H. Search				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO. 100-100000

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1923		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION None		7. MARITAL STATUS Single		8. EDUCATION High School		9. RELIGION Methodist		10. RACE White	
11. DECEASED AT Baltimore, Maryland		12. DATE OF DEATH June 4, 1968		13. TIME OF DEATH 10:00 AM		14. PLACE OF DEATH FBI Headquarters		15. CAUSE OF DEATH Suicide	
16. MANNER OF DEATH Suicide		17. MEDICAL HISTORY None		18. PREVIOUS ILLNESS None		19. SURVIVAL None		20. SIGNATURE OF DECEASED None	
21. SIGNATURE OF NEXT OF KIN None		22. SIGNATURE OF PHYSICIAN None		23. SIGNATURE OF CORONER None		24. SIGNATURE OF JURY None		25. SIGNATURE OF DEATH CERTIFICATE None	

BUREAU V. 3

JAN 14 1968

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
excise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00877

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Echo Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Echo Heights</u>	
c. LENGTH OF STAY IN lb <u>17 yrs</u>		d. STREET ADDRESS <u>5706 Mohican Pl</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5706 Mohican Pl.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas Joseph Kelley</u>		4. DATE OF DEATH <u>Jan 25 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-1914</u> 9. AGE (In years last birthday) <u>44</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P.E.P. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas J. Kelley Sr</u>		14. MOTHER'S MAIDEN NAME <u>Eli Barrett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>1-11-1914</u>	
17. INFORMANT <u>Eli Barrett Kelley - Son & Son 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1-25-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-28-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyson</u>		ADDRESS <u>1300-N ST. NW Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>JAN 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

FOR STATE
DEPARTMENT

RECEIVED
JAN 27 1938

BUREAU V. S.

JAN 27 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00878

CERTIFICATE OF DEATH

Reg. Dist. No.

828

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>642 Jefferson St. N.E.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Truman Almond Kennedy</u>				4. DATE OF DEATH Month Day Year <u>Jan. 20 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 30, 1917</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Union Representative</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Clerks</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. America</u>				13. FATHER'S NAME <u>Frank Kennedy</u>			
14. MOTHER'S MARDEN NAME <u>Lula Masemer</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW2</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Postoperative Shock -</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Surgery for Carcinoma rectum</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>7 days -</u> <u>3 months?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>1-16</u> , 19 <u>58</u> , to <u>1-20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 20</u> , 19 <u>58</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>John F. Brownberger</u> M.D.				<u>January 20 1958</u>			
PHYSICIAN'S NAME (Type) <u>John F. Brownberger</u>				<u>Takoma Park - Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>				ADDRESS <u>2901-14th St WASH. D. C. NW</u>			
24a. REC'D BY REGISTRAR <u>JAN 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Paul</u>					

DEPARTMENT OF HEALTH-BALTIMORE, MD.

JAN 22 1953

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	c. LENGTH OF STAY IN 1b 20 1/2 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roanoke 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc.		d. STREET ADDRESS 321 Berkeley Ave., Va. Heights	
3. NAME OF DECEASED (Type or print) First Middle Last Theodosia Earnest Kerr		4. DATE OF DEATH Month Day Year JAN 20 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 13, 1861
9. AGE (In years last birthday) 96 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Abram Moody		14. MOTHER'S MAIDEN NAME America Beckner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Asbury Methodist Home, Gaithersburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) cardiovascular disease congestive failure			INTERVAL BETWEEN ONSET AND DEATH 4 hrs 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-4 , 19 56 , to 1-2-4 , 19 58 , that I last saw the deceased alive on 1-8 , 19 58 , and that death occurred at 7:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sarah E. Glover 4208 Anthony St Kensington, Md 1/24/58 M.D. 4208 Anthony St Kensington, Md 1/24/58			
ACTUAL SIGNATURE Sarah E. Glover		PHYSICIAN'S NAME (Type) Sarah E. Glover	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-27-58	22c. NAME OF CEMETERY OR CREMATORY Forest Oak	22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.		ADDRESS Gaithersburg, Md.	
24a. REC'D BY REGISTRAR DATE JAN 27 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

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CERTIFICATE OF DEATH

Reg. Dist. No.

PLACE OF BIRTH		MARRIAGE		DEATH	
DATE OF BIRTH		DATE OF MARRIAGE		DATE OF DEATH	
AGE AT DEATH		AGE AT MARRIAGE		AGE AT BIRTH	
SEX		SEX		SEX	
RACE		RACE		RACE	
EDUCATION		EDUCATION		EDUCATION	
OCCUPATION		OCCUPATION		OCCUPATION	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
TIME OF DEATH		TIME OF DEATH		TIME OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	

BUREAU V. E.

JAN 27 1938

RECEIVED

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 906
 CERTIFICATE OF DEATH

00880

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 12 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Glenn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				d. STREET ADDRESS Castle Inn		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH First RENO Middle KRATZ Last				4. DATE OF DEATH Month January Day 14 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 15, 1885	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painting Contractor (Retired)				10b. KIND OF BUSINESS OR INDUSTRY Painting Contractor (Retired)		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Frank Kratz				14. MOTHER'S MAIDEN NAME Catherine Hilligass			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 197-01-1761		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arteriosclerosis insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary enthensea severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from Jan 13 , 19 58 , to Jan. 14 , 19 58 , that I last saw the deceased alive on Jan. 14 , 19 58 , and that death occurred at 2:15 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE J. W. Bird M.D. Sandy Spring, Maryland DATE SIGNED 1/14/58 PHYSICIAN'S NAME (Type) J. W. Bird 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 1/16/58 22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE UNION CEMETERY 22d. LOCATION (City, town, or county) (State) BURTONSVILLE, MONT. CO., MD. 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS Silver Spring 24a. REC'D BY REGISTRAR Jan 16 '58 24b. REGISTRAR'S SIGNATURE Alfred Smith							

IAN 16 1953

RECEIVED

907
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md. (Rural) c. LENGTH OF STAY IN 1b 2 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital NMMC, Bethesda, Md.				d. STREET ADDRESS 5029 Bradley Blvd. Apt #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last David Arthur LAMCZYK				4. DATE OF DEATH Month Day Year January 2 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 December 1957	
9. AGE (In years last birthday) 6 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Everett Eugene LAMCZYK			
14. MOTHER'S MAIDEN NAME Virginia LOHMAN				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT (Father) Everett E. LAMCZYK (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erythroblastosis Fetalis 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rh Blood Group incompatibility DUE TO (c) B.C.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 31 December, 1957 , to 2 January, 1958 , that I last saw the deceased alive on 2 January, 1958 , and that death occurred at 8:45A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Adam T. Thorp Jr.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, NMMC, Bethesda Md.			
DATE SIGNED 1-2-58				M.D. U.S. Naval Hospital, NMMC, Bethesda Md.			
PHYSICIAN'S NAME (Type) Adam T. THORP JR. LT MC USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-6-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey 7557 Wisconsin Ave. Bethesda Md.				24a. REC'D BY REGISTRAR AN 6 1958		24b. REGISTRAR'S SIGNATURE U. N. Hedrick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051373XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9 JAN 6 1958

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00882

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

1104 Lancaster Road,

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Johnson Rest Home

d. STREET ADDRESS

Takoma Park,

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

WILLIAM

First

Middle

Last

MORTIMER

LAMPTON

4. DATE
OF
DEATH

Month

Day

Year

January 31,

19 58

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

Apr. 6, 1872

9. AGE (In years
last birthday)

85 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

9 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired-Plate printer

10b. KIND OF BUSINESS OR INDUSTRY

Printing

11. BIRTHPLACE (State or foreign country)

Cedartown, Georgia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William M. Lampton

14. MOTHER'S MAIDEN NAME

Sue Battle

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Wm. N. Lampton-Same Item #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cerebral Infarction rt. Frontal Lobe

INTERVAL BETWEEN
ONSET AND DEATH

12 days

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. 988.7

DUE TO

Cerebral Arteriosclerosis

years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Bilateral bronchopneumonia

19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell in his room, striking head on floor or furniture

20c. TIME OF INJURY Month, Day, Year

Hour 7:15 p.m. 1/19/58

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Rest Home

20f. (City or town)

Silver Spring, Md.

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☐. Inquiry ☐. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐ACTUAL
SIGNATURE

Frank J. Broschart

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

2/1/58

EXAMINER'S
NAME (Type)

Frank J. Broschart M.D.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

2/3/1958

22c. NAME OF CEMETERY OR CREMATORY

Rockville Cemetery

22d. LOCATION (City, town, or county)

Rockville

(State)

Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.

24a. REC'D BY REGISTRAR

DATE FEB 3 '58

24b. REGISTRAR'S SIGNATURE

[Signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
DEPARTMENT

Montgomery

Livingston

Montgomery

1104 Lancaster Road

Livingston

Thomas I. B.

Livingston

January 21

LA

Livingston

April 8, 1972

White

Male

Georgetown, D. C.

Red and Blue Printing

See Battle

William M. Campbell

Wm. W. Campbell - Son - Item 22

to

George Washington University

George Washington University

George Washington University

George Washington University

BUREAU V. 1

EB 3 1968

RECEIVED

Frank J. Groschert
Rockville Cemetery
2/3/1952
Robert A. Thompson - Test Wils. vs. Burt. Md.

909

CERTIFICATE OF DEATH

00883

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 73 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 1609 Parham Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William David Leder				4. DATE OF DEATH Month Day Year January 12th 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 2, 1951	
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Max Leder				14. MOTHER'S MAIDEN NAME Maxine Rombro			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymphosarcoma DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 month 6 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 31, 19 57 to January 12, 19 58 , that I last saw the deceased alive on January 12, 19 58 , and that death occurred at 6:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 1-13-58 The National Institutes of Health Bethesda, Maryland							
ACTUAL SIGNATURE Dane R. Boggs M.D.				PHYSICIAN'S NAME (Type) Dane R. Boggs, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/58		22c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		22d. LOCATION (City, town, or county) (State) Falls Church, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons ADDRESS 3501 14th St., N.W.				24a. REC'D BY REGISTRAR DATE JAN 14 '58		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU - V. S.

JAN 14 1938

RECEIVED

829

CERTIFICATE OF DEATH

00884

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN TB <u>2 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month <u>Jan</u> Day <u>12</u> Year <u>1958</u>				5. SEX <u>Fe</u> 6. COLOR OR RACE <u>Cauc</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>3-6-87</u>				9. AGE (In years last birthday) <u>70</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Henderson</u>				14. MOTHER'S MAIDEN NAME <u>Martha Menzies</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>yes</u>			
17. INFORMANT <u>Hosp Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aneurysm R. mid. Cerebral artery</u> DUE TO <u>Arterial Hypertension (Chronic)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Undetermined (years)</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 1, 1958</u> to <u>Jan 12, 1958</u> that I last saw the deceased alive on <u>Jan 12, 1958</u> , and that death occurred at <u>10:55 AM</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>7835 Eastern Ave Jan 12, 1958</u>							
DATE SIGNED							
ACTUAL SIGNATURE <u>George L. Ball</u> M.D.							
PHYSICIAN'S NAME (Type) <u>George L. Ball Silver Spring Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>							
22b. DATE THEREOF <u>1/15/58</u>							
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>							
22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>Silver Spring, Md</u>							
24a. REC'D BY REGISTRAR <u>Jan 15 '58</u>							
24b. REGISTRAR'S SIGNATURE <u>Deberich</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Case No. 100

PLACE TO BE FILLED BY PHYSICIAN		NAME OF DECEASED [Faint text]	
SEX [Faint text]		AGE [Faint text]	
OCCUPATION [Faint text]		PLACE OF BIRTH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
CITY [Faint text]		COUNTY [Faint text]	
STATE [Faint text]		YEAR [Faint text]	

BUREAU V. S.

JAN 15 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00885

910

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	
d. STREET ADDRESS 7402 Carland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle Mae Last Lilley		4. DATE OF DEATH Month January Day 15 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 10, 1898
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR: Months 59 Days 59 Hours 59 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY Communications	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Moser		14. MOTHER'S MAIDEN NAME Otilia Reithmiller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-46-9309	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Increased intracranial pressure 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intracranial metastases DUE TO (c) Carcinoma of breast		INTERVAL BETWEEN ONSET AND DEATH 3 wks. 6 mos. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 30, 1957 , to January 15, 1958 , that I last saw the deceased alive on January 15, 1958 , and that death occurred at 8:45 A. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/15/58 ACTUAL SIGNATURE Kurt W. Kohn M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Kurt W. Kohn, M.D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 17, 1958	
22c. NAME OF CEMETERY OR CREMATORY National Memorial Park		22d. LOCATION (City, town, or county) (State) Falls Church, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll St NW S.C.		24a. REC'D BY REGISTRAR DATE JAN 17 '58	
24b. REGISTRAR'S SIGNATURE Alfred...			

RECEIVED
JAN 17 1958
BUREAU V. 8

911 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY New York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 640 Fort Washington Ave.	
3. NAME OF DECEASED (Type or print) First Joseph Middle Lewis Last LODGE		4. DATE OF DEATH Month January Day 9 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 March 1936
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	11. BIRTHPLACE (State or foreign country) New York
13. FATHER'S NAME Julius Y. LEIBOWITZ		14. MOTHER'S MAIDEN NAME Annette LEWIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 18 June 1957 to present		16. SOCIAL SECURITY NO. 004-32-8686	
17. INFORMANT Official Navy Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Polomyelitis anterior bulbar DUE TO 080.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from 6 January , 19 58 , to 9 January , 19 58 , that I last saw the deceased alive on 9 January , 19 58 , and that death occurred at 10:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-9-58 ACTUAL SIGNATURE J. T. Horgan M.D. U.S. Naval Hospital, Bethesda, Md. PHYSICIAN'S NAME (Type) J.T. HORGAN, LT, MC, USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-12-58	22c. NAME OF CEMETERY OR CREMATORY Mount Pleasant Cemetery	22d. LOCATION (City, town, or county) (State) Valhalla, New York
23. FUNERAL DIRECTOR'S SIGNATURE Chambers ADDRESS Chambers, 1400 Chapin St. Washington, D. C.		24a. REC'D BY REGISTRAR 1-9-58 DATE JAN 13 1958	24b. REGISTRAR'S SIGNATURE Attest

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 13 1958

RECEIVED

912

CERTIFICATE OF DEATH

Reg. Dist. No.

00887

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTG.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cara</u> Middle <u>Zeller</u> Last <u>Loeffler</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>17,</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 4, 1875</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Heilmandale, Pa.</u>		11. BIRTHPLACE (State or foreign country) <u>W.S.A.</u>	
13. FATHER'S NAME <u>John Miller</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Zeller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Raymond M. Oberholzer</u> Address <u>5503 Christy Dr. Springfield Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. _____ p. m. _____			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June</u> 19 <u>56</u> , to <u>Jan 17,</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 17,</u> 19 <u>58</u> , and that death occurred at <u>11:40 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert M. Havell</u> M.D.				ADDRESS (Street, city or town, state) <u>5576 Neb. Ave Washington DC</u>		DATE SIGNED <u>1-18-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert M. Havell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>1/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fredericksburg, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co</u>				ADDRESS <u>2901-14th St. NW Wash. D. C.</u>		24a. REC'D BY REGISTRAR <u>Jan 20 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. L. L. L.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

115

1958

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIAGE		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. DATE OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERVIEWER	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWER	
28. SIGNATURE OF INTERVIEWER		29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWER	
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97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWER	
100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWER		102. SIGNATURE OF INTERVIEWER	

RECEIVED
JAN 20 1958
BUREAU V. S.

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 9 Film G224 1-23-58 et
 913 CERTIFICATE OF DEATH

00888

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ASHTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belmont NURSING HOME</u>		d. STREET ADDRESS <u>RT #1 BOX 203</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jannia GANET Lowe</u>		4. DATE OF DEATH Month Day Year <u>JAN. 11 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 3, 1883</u>
9. AGE (In years last birthday) <u>74 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE - RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPHUA BROWNING</u>		14. MOTHER'S MAIDEN NAME <u>MARY GIBSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. MYRTLE Y. FREMEAUX</u>		Address <u>400 BEALL AVE. ROCKVILLE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 weeks</u> <u>years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/10/58</u> , 19 <u>58</u> , to <u>1/11/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/10/58</u> , 19 <u>58</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. Bird</u>		ADDRESS (Street, city or town, state) <u>Sandy Spring Md</u>	
PHYSICIAN'S NAME (Type) <u>J. W. Bird</u>		DATE SIGNED <u>1/11/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT. CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>FT. MYER VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>		ADDRESS <u>517-11 4th St. S.E.</u>	24a. REC'D BY REGISTRAR <u>15 '58</u>
24b. REGISTRAR'S SIGNATURE <u>Chambers</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

914 CERTIFICATE OF DEATH

Reg. Dist. No. 00889

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Browningsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Browningsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Monrovia				d. STREET ADDRESS R.F.D. Monrovia			
3. NAME OF DECEASED (Type or print) First Jackie Middle Lee Last Lowe				4. DATE OF DEATH Month Jan. Day 23 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1957		9. AGE (In years last birthday) — yrs.	IF UNDER 1 YEAR Months 27 Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Olney, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Leroy Lowe				14. MOTHER'S MAIDEN NAME Marie F. Neal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. --		17. INFORMANT James Leroy Lowe, Damascus, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 20 , 19 58 , to Jan. 23 , 19 58 , that I last saw the deceased alive on Jan. 21 , 19 58 , and that death occurred at 1:00 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr				ADDRESS (Street, city or town, state) Damascus, Md.		DATE SIGNED 1/24/58	
PHYSICIAN'S NAME (Type) James P. Kerr				Damascus, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1958		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Moleworth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE JAN 27 '58	
				24b. REGISTRAR'S SIGNATURE Alfred Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

915

CERTIFICATE OF DEATH

00890
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery County General Hospital				d. STREET ADDRESS 13601 St. Mary's Road			
3. NAME OF DECEASED (Type or print) First Kathleen Middle BROWN Last Lucas				4. DATE OF DEATH Month January Day 10 Year 58			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/11/10 March 11, 1910	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 10 Days 19 Hours 58		IF UNDER 24 HRS. Hours 19 Min. 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Monroe Brown Reeves				14. MOTHER'S MAIDEN NAME Martha Little			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 406-28-6508		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154x Inanition DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of Rectum DUE TO (c) Adenocarcinoma of Rectum						INTERVAL BETWEEN ONSET AND DEATH 3 hrs 6 hrs 18 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov , 19 56 , to 1/10 , 19 58 , that I last saw the deceased alive on Jan 10 , 19 58 , and that death occurred at 7:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) Sandy Spring, Maryland			
DATE SIGNED 1/11/58							
PHYSICIAN'S NAME (Type) C. H. Ligon, M. D., Sandy Spring, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
TRANS. & BURIAL		1/13/58		MARTINSVILLE CEMETERY		MARTINSVILLE, OHIO	
23. FUNERAL DIRECTOR'S SIGNATURE Warner & Humphrey, Silver Spring, Md.				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR JAN 13 '58	
				24b. REGISTRAR'S SIGNATURE [Signature]			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00891

845

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Minor Country Club		e. STREET ADDRESS 4022 WARREN STREET, N.W.	
3. NAME OF DECEASED (Type or print) THEODORE NEAL MacKay		4. DATE OF DEATH Month Jan. Day 18 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/30/96
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUDITOR		10b. KIND OF BUSINESS OR INDUSTRY U.S. WAR DEPT.	11. BIRTHPLACE (State or foreign country) MASS.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Miss Rita J. Benoit, 4607 Conn. Ave., N.W. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell dead on # 3 Green, Manor Club while playing golf			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Jan. 18, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/21/58	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Pumphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR JAN 23 '58		24b. REGISTRAR'S SIGNATURE W. E. Pumphrey	

STATE
ATTENDANT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 23 1938
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

: 916 CERTIFICATE OF DEATH

00892

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) Maple Lake San. 9810 Georgia Ave. S. Rd.				d. STREET ADDRESS 1311 Juniper Street, N.W.			
3. NAME OF DECEASED (Type or print) ELLEN First Middle Last				4. DATE OF DEATH JAN 1 1958 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 14 - 1869	
9. AGE (In years last birthday) 88 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) IRELAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John Love			
14. MOTHER'S MAIDEN NAME Ann Ritchie				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Charles H. MacMurray Address Washington D.C. 1311 Juniper St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ESSENTIAL HYPERTENSION							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Nov. 27, 1957 , to Jan 1 - 1958 , that I last saw the deceased alive on 1-1- , 1958 , and that death occurred at 8 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry M. Lowden M.D.				ADDRESS (Street, city or town, state) 5206 NORWAY DR. 11/58			
DATE SIGNED 1/1/58				PHYSICIAN'S NAME (Type) HENRY M. LOWDEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/4/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St., N.W.				ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR JAN 6 1958	
24b. REGISTRAR'S SIGNATURE U. M. Drichy							

Montgomery Co.

Highgate Ave. 216-218

Female White

July 11 - 1889

Housewife

IRELAND

N.A.A.

John, Love

IRELAND

CHARLES H. MONTGOMERY

Mass. State Dept. of Health

BUREAU V. S.

1-1-1

AN 6 1938

RECEIVED

CERTIFICATE OF DEATH

00893
Reg. Dist. No.

917

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>G.</u> Last <u>Maddren</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 5, 1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Geologist, U.S. G.S.</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Joseph Maddren</u>				14. MOTHER'S MAIDEN NAME <u>Isabella Annie Geddes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>H. H. Maddres, 424 North Arden Blvd. Los Angeles 4, California</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obstructive uropathy</u> DUE TO (c) <u>Carcinoma of Prostate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Myelogenous leukemia</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> years years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3 January</u> , 19 <u>58</u> , to <u>4 January</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4 January</u> , 19 <u>58</u> , and that death occurred at <u>10:15 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8218 W. Green Ave Bethesda, Md</u> DATE SIGNED <u>4 Jan 58</u>							
ACTUAL SIGNATURE <u>Edward E. Ferguson</u> M.D.							
PHYSICIAN'S NAME (Type) <u>EDWARD E. FERGUSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Humphrey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

918 CERTIFICATE OF DEATH

Reg. Dist. No. 00894

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>FAIRFAX, Co.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1 week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>811 Pinewood Terrace</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Bernard</u> Last <u>Maher</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/2/02</u>	9. AGE (In years lost birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oneida, N.Y.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William James Maher</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Buens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Mrs W. Bernard Maher (wife)</u>		Address <u>Same as 1b</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis, severe</u> <u>578X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforation, ileum</u> DUE TO (c) <u>2 day</u> <u>2 day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 4</u> , 1956, to <u>Jan 4</u> , 1958, that I last saw the deceased alive on <u>Jan 4</u> , 1958, and that death occurred at <u>10:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingoman St. NW Wash 15 D.C.</u> DATE SIGNED <u>Jan 4 1958</u>							
ACTUAL SIGNATURE <u>Stewart Clapp</u>				M.D. <u>3921 Ingoman St. NW Wash 15 D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>1/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ONEIDA, NEW YORK</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumpfney</u> ADDRESS <u>8454 1/2 Ave SE, NE</u>				24a. REC'D BY REGISTRAR <u>Jan 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1958 8 1958

RECEIVED

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00895

919

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 24 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS 240 Washington St., Apt. #5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Mahone				4. DATE OF DEATH Month January Day 26 Year 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/25/58	
9. AGE (In years last birthday) 24		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charles Mahone			
14. MOTHER'S MAIDEN NAME Jean Smith				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Jean Mahone Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Atelctaris DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH One day							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour a. 11. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Rockville				20g. (County) (State)			
21. I certify that I attended the deceased from 1-25 , 19 58 , to 1-26 , 19 58 , that I last saw the deceased alive on 1-26 , 19 58 , and that death occurred at 12:15 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack Schumacher M.D.				ADDRESS (Street, city or town, state) Gaithersburg, Md. DATE SIGNED 1-27-58			
PHYSICIAN'S NAME (Type) Jack Schumacher, M. D.				ADDRESS Gaithersburg, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-2-58		22c. NAME OF CEMETERY OR CREMATORY Lincoln Park		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snodden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE FEB 10 '58	
24b. REGISTRAR'S SIGNATURE Reed							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		Male		White		1893		Baltimore		Baltimore		Baltimore		Maryland	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH		CITY		COUNTY	
Carpenter		High School		Married		Roman Catholic		Heart Disease		Several Months		Baltimore		Baltimore		Maryland	
DATE OF DEATH		HOUR OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		WEIGHT		HEIGHT		BUILD	
Feb 10 1938		10:00 AM		100.0		70		20		120/80		170		5' 8"		Medium	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. S.

FEB 10 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

830

CERTIFICATE OF DEATH

00896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>17 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hospital</i>		d. STREET ADDRESS <i>1502 East West Highway</i>	
3. NAME OF DECEASED (Type or print) First <i>May</i> Middle <i>Agnes</i> Last <i>Maloney</i>		4. DATE OF DEATH Month <i>1</i> Day <i>12</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>December 9-1932</i> 9. AGE (In years last birthday) <i>26</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance Business</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Gallagher</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Corcoran</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>?</i>	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> DUE TO <i>332X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral arteriosclerosis</i> DUE TO (c) <i>Generalized arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i> <i>probably</i> <i>years</i> <i>at least</i> <i>5 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic-Hypertensive Heart Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov</i> 1957, to <i>January 12, 1958</i> , that I lost saw the deceased olive on <i>January 11</i> , 1958, and that death occurred at <i>2:40 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Aaron H. Traum MD</i>		ADDRESS (Street, city or town, state) <i>8237 Georgia Ave Silver Spring, Md</i> DATE SIGNED <i>Jan 12 58</i>	
PHYSICIAN'S NAME (Type) <i>Aaron H. Traum</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Ship-BURIAL</i>	22b. DATE THEREOF <i>Jan. 16, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>HOLY CROSS CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>BROOKLYN, NEW YORK</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Rumphrey</i> ADDRESS <i>Silver Spring Md</i>		24a. REC'D BY REGISTRAR <i>W. F. Leach</i> 24b. REGISTRAR'S SIGNATURE <i>W. F. Leach</i> DATE <i>1 4 '58</i>	

14 JAN 1958

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00897

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck	c. LENGTH OF STAY IN 1b 1 1/2 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural --- City 13 St. Philomena's Nursing Home		d. STREET ADDRESS 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) CHARLES A. MANSFIELD		4. DATE OF DEATH Month Jan. Day 1, Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1872
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min. 85	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer --- Retired		10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Charles Mansfield	
14. MOTHER'S MAIDEN NAME Anne Norris		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 220-12-2688		17. INFORMANT Mrs. Ella Broadhurst	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) hypertension stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH sudden years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschert		DATE SIGNED 1-2-58	
EXAMINER'S NAME (Type) FRANK J. Broschert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-4-58	22c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery	22d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland		24a. REC'D BY REGISTRAR 1958	
24b. REGISTRAR'S SIGNATURE A. Mednick			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 32
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
BOND

BUREAU V. S.

JAN 6 1953

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. ~~XXX~~

215

921

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. STREET ADDRESS 1218 Rockville Pike	
3. NAME OF DECEASED (Type or print) First Wilbert Middle Frederick Last MARLOW		4. DATE OF DEATH Month January Day 26 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 28 January 1910
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Herford MARLOW		14. MOTHER'S MAIDEN NAME Anna Marie JOACHIM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1927 to 1957		16. SOCIAL SECURITY NO. 577 44 9643	
17. INFORMANT (Brother) Clarence E. MARLOW (P.O. BOX 265,)		Address (Landover, Md.)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Infarction myocardium DUE TO (b) Coronary sclerosis DUE TO (c) Indef.		INTERVAL BETWEEN ONSET AND DEATH 15 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 January, 1958 , to 26 January, 1958 , that I last saw the deceased alive on 26 January, 1958 , and that death occurred at 1:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. J. Mc Carthy		ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 1-27-58	
PHYSICIAN'S NAME (Type) R. J. MC CARTHY, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey, 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR JAN 30 1958	
24b. REGISTRAR'S SIGNATURE W. J. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

IMPERIAL STATE DEPARTMENT OF HEALTH - BUREAU OF
CERTIFICATE OF DEATH

BUREAU V. 5

JAN 30 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

922

CERTIFICATE OF DEATH

Reg. Dist. No.

00899

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Grove		c. LENGTH OF STAY IN 1b 3 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Grove	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Charles First Haviland Middle Matthews Last			4. DATE OF DEATH Jan. Month 8 Day 1958 Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3 1865		9. AGE (In years last birthday) 92 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Wesley Matthews			14. MOTHER'S MAIDEN NAME Charlotte Cromwell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ##### (If yes, give war or dates of service) #####		16. SOCIAL SECURITY NO. None		17. INFORMANT Address NE Mrs. Gordon Benson, 1235 Newton St. D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility 794x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 years					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 2-9- , 19 55 , to 8-8- , 19 58 , that I last saw the deceased alive on 1-6- , 19 58 , and that death occurred at 4:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____					
ACTUAL SIGNATURE William C. Miller M.D.					
PHYSICIAN'S NAME (Type) William C. Miller 7 Br. Ave Gaithersburg, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 11.58		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel	
22d. LOCATION (City, town, or county) Unity		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber			ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE JAN 14 '58
24b. REGISTRAR'S SIGNATURE Reverend					

CERTIFICATE OF DEATH

Name of Deceased Charles, Haviland, Matthews		Sex Male	
Date of Birth Dec. 3 1885		Race White	
Usual Residence Maryland		Place of Birth Maryland	
Date of Death Jan. 11 1958		Cause of Death (To be filled in by physician)	
Place of Death (To be filled in by physician)		Signature of Physician (To be filled in by physician)	
Name of Informant Mrs. Gordon Benson, 1535 Newton St. D.C.		Signature of Informant (To be filled in by informant)	
Date of Report Jan. 14 1958		Signature of Registrar (To be filled in by registrar)	

RECEIVED

JAN 14 1958

BUREAU V. S.

William C. Miller

Jan. 11.58

Laytonville, Md.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. HENRY		45		M		W		JAN 27 1938		BOSTON, MASS.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.	
100 N. ST.		LABORER		HEART DISEASE		NATURAL		100		100	
BIRTH DATE		BIRTH PLACE		EDUCATION		MARRIAGE		SIGNED		NOTED	
JAN 15 1893		MASS.		8		M		JAN 27 1938		JAN 27 1938	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S BIRTH DATE		MOTHER'S BIRTH DATE	
JAMES J. HENRY		MARY J. HENRY		LABORER		HOUSEWIFE		JAN 15 1868		JAN 15 1868	
FATHER'S BIRTH PLACE		MOTHER'S BIRTH PLACE		FATHER'S DEATH DATE		MOTHER'S DEATH DATE		FATHER'S DEATH PLACE		MOTHER'S DEATH PLACE	
MASS.		MASS.		JAN 15 1938		JAN 15 1938		MASS.		MASS.	
FATHER'S DEATH CAUSE		MOTHER'S DEATH CAUSE		FATHER'S DEATH MANNER		MOTHER'S DEATH MANNER		FATHER'S DEATH CERT. NO.		MOTHER'S DEATH CERT. NO.	
HEART DISEASE		HEART DISEASE		NATURAL		NATURAL		100		100	
FATHER'S DEATH PLACE		MOTHER'S DEATH PLACE		FATHER'S DEATH DATE		MOTHER'S DEATH DATE		FATHER'S DEATH PLACE		MOTHER'S DEATH PLACE	
MASS.		MASS.		JAN 15 1938		JAN 15 1938		MASS.		MASS.	

RECEIVED
 JAN 27 1938
 BUREAU V. S.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1511 Underwood st., N.W.	
3. NAME OF DECEASED (Type or print) First Nellie Middle Gertrude Last McCarthy		4. DATE OF DEATH Month January Day 22 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22 1889
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 5 Days 6 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael W. Calnan		14. MOTHER'S MAIDEN NAME Isabelle G. Harvey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Abscess/ Pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 002x (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malignant Lymphoma (Suspected because of gross autopsy findings.)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington, D.C.		(County) (State)	
21. I certify that I attended the deceased from December 30, 1957 , to January 22, 1958 , that I last saw the deceased alive on January 22, 1958 , and that death occurred at 9:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/22/58			
ACTUAL SIGNATURE Norman H. Bell		M.D. The Clinical Center	
PHYSICIAN'S NAME (Type) NORMAN H. BELL		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/25/1958	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.		ADDRESS 317 Pa. Ave., SE	
24a. REC'D BY REGISTRAR Jan 24 '58		24b. REGISTRAR'S SIGNATURE Q. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the general director should be detached for use as the burial-transit permit. Then please remove carbon papers.
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page Two

BUREAU V. S.

JAN 24 1953

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<p>1. Name of deceased: John Doe</p>		<p>2. Date of death: January 23, 1953</p>	
<p>3. Place of death: Washington, D.C.</p>		<p>4. Age at death: 55 years</p>	
<p>5. Sex: Male</p>		<p>6. Race: White</p>	
<p>7. Occupation: Government</p>		<p>8. Cause of death: Heart Disease</p>	
<p>9. Medical history: Ischemic heart disease, hypertension</p>		<p>10. Attending physician: Dr. J. A. Smith</p>	
<p>11. Signature of physician: [Signature]</p>		<p>12. Date of certificate: January 24, 1953</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

925

CERTIFICATE OF DEATH

00902

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1438 Columbia Road, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Manus Middle Ignatious Last McGowan		4. DATE OF DEATH Month January Day 13 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1890
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick layer		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew McGowan		14. MOTHER'S MAIDEN NAME Annie Farr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-03-1392	
17. INFORMANT The Medical Record Address		17. INFORMANT The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, ? Septicemia DUE TO 142.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Malignant Mixed Tumor of DUE TO Parotid Gland to lungs, esophagus, etc. (c) Multiple pulmonary abscess INTERVAL BETWEEN ONSET AND DEATH 5 days 9 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 29, 19 57 , to January 13, 19 58 , that I last saw the deceased alive on January 13, 19 58 , and that death occurred at 6:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/13/58 ACTUAL SIGNATURE Peter D. Olch M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Peter D. Olch, M. D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) 1/16/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.,		24a. REC'D BY REGISTRAR 15 58	
24b. REGISTRAR'S SIGNATURE Wash, D.C.			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES J. JONES		JAN 15 1958	
AGE		SEX	
45		M	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
C		I	
PLACE OF DEATH		DATE OF BURIAL	
H		JAN 15 1958	
CITY		STATE	
B		M	
COUNTRY		SIGNATURE OF PHYSICIAN	
U		J. J. JONES	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 15 1958		JAN 15 1958	

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JAN 15 1958
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

831

CERTIFICATE OF DEATH

Reg. Dist. No.

00903

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>		d. STREET ADDRESS <u>14 Crescent Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Stanley</u> Middle <u>Elwin</u> Last <u>McNeill</u>		4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-31-77</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>5</u> Hours <u>19</u> Min. <u>58</u>	IF UNDER 24 HRS. Months <u>8</u> Days <u>5</u> Hours <u>19</u> Min. <u>58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>u.s.a.</u>	
13. FATHER'S NAME <u>Alfred McNeill</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Washington San & Hosp Records - 7600 Carroll Ave</u>	
17. INFORMANT Address <u>Washington San & Hosp Records - 7600 Carroll Ave</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 420.0 DUE TO <u>Old Arteriosclerotic Heart Disease</u> (b) <u>Old Arteriosclerotic Heart Disease</u> DUE TO <u>Old Arteriosclerotic Heart Disease</u> (c) <u>Old Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/3</u> , 19 <u>58</u> , to <u>1/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/5</u> , 19 <u>58</u> , and that death occurred at <u>1:50</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard T. Morse</u>		ADDRESS (Street, city or town, state) <u>2030 Carroll Ave</u> DATE SIGNED <u>1/5/58</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD T. MORSE</u>		Tobacco Park, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 11, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alphonse Salvo</u> ADDRESS <u>254 Carroll St NW</u>		24. REC'D BY REGISTRAR <u>Alphonse Salvo</u> DATE <u>JAN 7 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alphonse Salvo</u>		24c. REGISTRAR'S SIGNATURE <u>Alphonse Salvo</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. PLACE OF DEATH		6. TIME OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. PLACE OF BIRTH		12. OCCUPATION	
13. MARITAL STATUS		14. EDUCATION		15. RELIGION	
16. PREVIOUS ILLNESS		17. PRESENT ILLNESS		18. MEDICAL ATTENDANCE	
19. PHYSICIAN'S SIGNATURE		20. COUNTY HEALTH OFFICER'S SIGNATURE		21. DATE OF DEATH	
22. COUNTY OF DEATH		23. STATE OF DEATH		24. COUNTY OF BIRTH	
25. STATE OF BIRTH		26. COUNTY OF BIRTH		27. STATE OF BIRTH	
28. COUNTY OF BIRTH		29. STATE OF BIRTH		30. COUNTY OF BIRTH	
31. STATE OF BIRTH		32. COUNTY OF BIRTH		33. STATE OF BIRTH	
34. COUNTY OF BIRTH		35. STATE OF BIRTH		36. COUNTY OF BIRTH	
37. STATE OF BIRTH		38. COUNTY OF BIRTH		39. STATE OF BIRTH	
40. COUNTY OF BIRTH		41. STATE OF BIRTH		42. COUNTY OF BIRTH	
43. STATE OF BIRTH		44. COUNTY OF BIRTH		45. STATE OF BIRTH	
46. COUNTY OF BIRTH		47. STATE OF BIRTH		48. COUNTY OF BIRTH	
49. STATE OF BIRTH		50. COUNTY OF BIRTH		51. STATE OF BIRTH	
52. COUNTY OF BIRTH		53. STATE OF BIRTH		54. COUNTY OF BIRTH	
55. STATE OF BIRTH		56. COUNTY OF BIRTH		57. STATE OF BIRTH	
58. COUNTY OF BIRTH		59. STATE OF BIRTH		60. COUNTY OF BIRTH	
61. STATE OF BIRTH		62. COUNTY OF BIRTH		63. STATE OF BIRTH	
64. COUNTY OF BIRTH		65. STATE OF BIRTH		66. COUNTY OF BIRTH	
67. STATE OF BIRTH		68. COUNTY OF BIRTH		69. STATE OF BIRTH	
70. COUNTY OF BIRTH		71. STATE OF BIRTH		72. COUNTY OF BIRTH	
73. STATE OF BIRTH		74. COUNTY OF BIRTH		75. STATE OF BIRTH	
76. COUNTY OF BIRTH		77. STATE OF BIRTH		78. COUNTY OF BIRTH	
79. STATE OF BIRTH		80. COUNTY OF BIRTH		81. STATE OF BIRTH	
82. COUNTY OF BIRTH		83. STATE OF BIRTH		84. COUNTY OF BIRTH	
85. STATE OF BIRTH		86. COUNTY OF BIRTH		87. STATE OF BIRTH	
88. COUNTY OF BIRTH		89. STATE OF BIRTH		90. COUNTY OF BIRTH	
91. STATE OF BIRTH		92. COUNTY OF BIRTH		93. STATE OF BIRTH	
94. COUNTY OF BIRTH		95. STATE OF BIRTH		96. COUNTY OF BIRTH	
97. STATE OF BIRTH		98. COUNTY OF BIRTH		99. STATE OF BIRTH	
100. COUNTY OF BIRTH		101. STATE OF BIRTH		102. COUNTY OF BIRTH	

BUREAU V. E.

JAN 7 1958

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>315 N. Van Buren St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Russell McKinley Meade</u>		4. DATE OF DEATH <u>1-2-1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-98</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chamber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>M.S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>M.S.C.</u>	
13. FATHER'S NAME <u>George W. Mead</u>		14. MOTHER'S MARDEN NAME <u>Rose Rozier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Russell Campbell - same as item 2</u>	
17. INFORMANT <u>Russell Campbell - same as item 2</u>		Address <u>same as item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>same as (a)</u> (c) <u>same as (a)</u> DUE TO Cause lost. (c) <u>same as (a)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>same as (a)</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Snodden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>same as (a)</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>0</u> a. m. <u>0</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>same as (a)</u>		20f. (City or town) (County) (State) <u>same as (a)</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/3/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Search</u>	

RECEIVED

JAN 2 1958

BUREAU V. S.

RECEIVED
JAN 2 1958
BUREAU V. S.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH OFFICE

LOCAL OFFICE
JAN 2 1958

NAME OF DECEASED
SEX
AGE
RACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF MEDICAL EXAMINER
OFFICIAL SEAL OF MEDICAL EXAMINER

926

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Mont			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 18 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 11806 Grand View Ave.			
3. NAME OF DECEASED (Type or print) First Harriet Middle Virginia Last MEHOVES				4. DATE OF DEATH Month January Day 6 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 July 1899	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Lee C. HUMPHRIES				14. MOTHER'S MAIDEN NAME Harriet Ann SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Son) John Herman MEHOVES (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 170x DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 14 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 December, 19 57 , to 6 January, 19 58 , that I last saw the deceased alive on 6 January, 19 58 , and that death occurred at 7:25 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.				DATE SIGNED 1-6-58			
ACTUAL SIGNATURE Martin Plaut				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) Martin Plaut, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-9-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				ADDRESS 1400 Chapin St., Washington, D.C.		24a. REC'D BY REGISTRAR DATE 1-JAN-58 '58	
24b. REGISTRAR'S SIGNATURE Alfred Leach							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

6 JAN 1958

RECEIVED

832

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>18315 Garland Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last (<u>Unnamed</u>) <u>Infant Boy</u> <u>Miller</u>		4. DATE OF DEATH Month Day Year <u>1</u> <u>11</u> <u>1958</u>	
5. SEX <u>Boy</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-58</u>
9. AGE (In years last birthday) yrs. <u>35</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>35</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William David Miller, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Jeanne Estelle Plant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mother's hospital record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - at 22 wks. gestation</u> 774x DUE TO (b) <u>cause unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2:55 P.M. 1-11-58</u> to <u>3:30 P.M. 1-11-58</u> , that I last saw the deceased alive on <u>1-11-58</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emma Hughes</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave. Takoma Park 12, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Emma Hughes, M.D.</u>		DATE SIGNED <u>1-13-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>1-16-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hospital, Takoma Park, Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D.</u> ADDRESS <u>Wash. San. & Hospital</u>		24a. REC'D BY REGISTRAR <u>JAN 20 58</u> DATE	24b. REGISTRAR'S SIGNATURE <u>W. S. Church</u>

2075361XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Form 10-1-1934

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]	
6. OCCUPATION [Faint text]		7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]		10. PLACE OF DEATH [Faint text]	
11. SIGNATURE OF DECEASED [Faint text]		12. SIGNATURE OF WITNESS [Faint text]		13. SIGNATURE OF PHYSICIAN [Faint text]		14. SIGNATURE OF CORONER [Faint text]		15. SIGNATURE OF JURY [Faint text]	
16. SIGNATURE OF REGISTRAR [Faint text]		17. SIGNATURE OF CLERK [Faint text]		18. SIGNATURE OF ASSISTANT CLERK [Faint text]		19. SIGNATURE OF CHIEF CLERK [Faint text]		20. SIGNATURE OF DEPUTY CHIEF CLERK [Faint text]	

BUREAU V. S.

JAN 20 1938

RECEIVED

927

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4804 Somerset Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Clarence Middle William Last Miller				4. DATE OF DEATH Month January Day 11 , Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1905	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason				10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Miller				14. MOTHER'S MAIDEN NAME Martha Orndorff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 579-09-8000		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, massive, left. 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Myelocytic Leukemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 hrs. 2 - 3 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 9 , 19 58 , to January 11 , 19 58 , that I last saw the deceased alive on January 11 , 19 58 , and that death occurred at 2:30 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Sherman Weissman				ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 1/11/58	
PHYSICIAN'S NAME (Type) SHERMAN WEISSMAN, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		1-14-58		77 Lincoln Cemetery		Bladensburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS 588 Cleveland Ave		24a. REC'D BY REGISTRAR Alfred	
						24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Patient		John Major	
Age		30 years	
Sex		Male	
Race		White	
Date of Birth		April 8, 1903	
Place of Birth		New Virginia	
Occupation		None	
Address		The Clinical Center, Baltimore 12, Md.	
Physician		The Clinical Center, Baltimore 12, Md.	
Referral		The Clinical Center, Baltimore 12, Md.	
Admission Date		April 8, 1953	
Admission Time		11:00 AM	
Admission Place		The Clinical Center, Baltimore 12, Md.	
Admission Reason		The Clinical Center, Baltimore 12, Md.	
Admission Status		The Clinical Center, Baltimore 12, Md.	
Admission Type		The Clinical Center, Baltimore 12, Md.	
Admission Class		The Clinical Center, Baltimore 12, Md.	
Admission Grade		The Clinical Center, Baltimore 12, Md.	
Admission Level		The Clinical Center, Baltimore 12, Md.	
Admission Rank		The Clinical Center, Baltimore 12, Md.	
Admission Position		The Clinical Center, Baltimore 12, Md.	
Admission Status		The Clinical Center, Baltimore 12, Md.	
Admission Type		The Clinical Center, Baltimore 12, Md.	
Admission Class		The Clinical Center, Baltimore 12, Md.	
Admission Grade		The Clinical Center, Baltimore 12, Md.	
Admission Level		The Clinical Center, Baltimore 12, Md.	
Admission Rank		The Clinical Center, Baltimore 12, Md.	
Admission Position		The Clinical Center, Baltimore 12, Md.	

BUREAU V. E.

THE CLINICAL CENTER
NATIONAL INSTITUTES OF HEALTH
Baltimore 12, Md.

RECEIVED

833

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>3606 EVERTON ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MRS. CAMILLE MARIE MOORE</u>				4. DATE OF DEATH Month Day Year <u>1-19 1958</u>			
5. SEX <u>fe</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-21</u>	9. AGE (In years last birthday) <u>36</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>Filippo Anthony Capone</u>				14. MOTHER'S MAIDEN NAME <u>Maria Grazia Morfesi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-28-9401</u>		17. INFORMANT Address <u>As Chmt - Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chondrosarcoma Metastatic</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>57</u> , to <u>Jan-19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan-19</u> , 19 <u>58</u> , and that death occurred at <u>11:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Isidore Shulman</u> M.D. <u>9-15-1958</u> <u>Wash. C. D.</u> PHYSICIAN'S NAME (Type) <u>Isidore Shulman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/22/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold E. Humphrey</u>		ADDRESS <u>Silver Spring, Md</u>		24a. REC'D BY REGISTRAR <u>Al. Beach</u>	24b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

928

CERTIFICATE OF DEATH

00909

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN TB 25 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Webster Springs 85 x - 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS (no street address)	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First George Middle Weldon Last Morton		4. DATE OF DEATH Month January Day 27 , Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1908
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tipple Foreman		10b. KIND OF BUSINESS OR INDUSTRY Mining	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George R. Morton		14. MOTHER'S MAIDEN NAME Hettie Withrow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stokes-Adams Attack 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic Stenosis DUE TO (c) Rheumatic Heart Disease, Inactive			INTERVAL BETWEEN ONSET AND DEATH 5 Years 20 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Esophagitis and Gastritis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 2, 19 58 , to January 27, 19 58 , that I last saw the deceased alive on January 27, 19 58 , and that death occurred at 1:43 P M, from the causes and on the date stated above. 1:45 pm ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Louis Gillespie, Jr. M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) LOUIS GILLESPIE M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-30-58	22c. NAME OF CEMETERY OR CREMATORY Blacks Chapel Cemetery	22d. LOCATION (City, town, or county) (State) Camden on Gauley
23. FUNERAL DIRECTOR'S SIGNATURE Neal Funeral Home		ADDRESS 4812 La Salle Washington	
24a. REC'D BY REGISTRAR DATE FEB 3 '58		24b. REGISTRAR'S SIGNATURE W. L. Smith	

CERTIFICATE OF DEATH

BUREAU V. 2

FEB 3 1939

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00910

929

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Silver Spring		c. LENGTH OF STAY IN 1b I Year		
d. NAME OF HOSPITAL (If not in hospital, give street address) Marilee Nurseing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JAMES First ARTHUR Middle MULLICAN Last		4. DATE OF DEATH January Month IO Day 19 Year 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5 1863	
9. AGE (In years at birthday) 94 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Gen. Building		
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Mulligan		14. MOTHER'S MAIDEN NAME Rachel Ricketts		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ##### (If yes, give date of service) #####		16. SOCIAL SECURITY NO. None		
17. INFORMANT Thomas T. Mullican, Derwood, Md. Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) L.V.A. (multiple over period of 14 days) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) —				INTERVAL BETWEEN ONSET AND DEATH 14 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) No.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from April 2, 1957 , to Jan 19, 1958 , that I last saw the deceased alive on Jan 2, 1958 , and that death occurred at 4:45 A.M. from the causes and on the date stated above.				
ACTUAL SIGNATURE John S. Rogers M.D.		ADDRESS (Street, city or town, state) Silver Spring Md. DATE SIGNED 1958 January 19 1958		
PHYSICIAN'S NAME (Type) John S. Rogers				
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF Jan. 12 1958		
22c. NAME OF CEMETERY OR CREMATORY Forrest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR JAN 14 58 DATE		
24b. REGISTRAR'S SIGNATURE				

Wm. Sullivan

930

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont 85 x 9	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda, Md.		d. STREET ADDRESS 225 Watson Ave.	
3. NAME OF DECEASED (Type or print) First Matthew Middle Mansfield Last NEELY		4. DATE OF DEATH Month January Day 18 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 November 1874
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Senator		10b. KIND OF BUSINESS OR INDUSTRY Politics	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alfred NEELY		14. MOTHER'S MAIDEN NAME Harriette MORRIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes, Spanish American		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of The Prostate with metastasis to bones and lungs 177X DUE TO (b) metastasis to bones and lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 20 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3 September, 19 57 , to 18 January, 19 58 , that I last saw the deceased alive on 18 January, 19 58 , and that death occurred at 10:09 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thirl E. Jarrett M.D.		ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 1-18-58	
PHYSICIAN'S NAME (Type) Thirl E. Jarrett, CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-22-58	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Fairmont, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumpfrey		24a. REC'D BY REGISTRAR DATE JAN 22 '58	24b. REGISTRAR'S SIGNATURE W. H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 8

JAN 22 1938

RECEIVED

931

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Beatrice Middle (None) Last Neidich		4. DATE OF DEATH Month January Day 1 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1913
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Morris Weinberg		14. MOTHER'S MAIDEN NAME Dora Weinberg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 057-16-8299	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Metastatic Carcinoma to Left Lung. DUE TO (c) Carcinoma of Left Breast.			INTERVAL BETWEEN ONSET AND DEATH 1 week 1 month 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 23, 19 57 , to January 1, 19 58 , that I last saw the deceased alive on January 1, 19 58 , and that death occurred at 12:03 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Allen Goodman</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 1/1/58 National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) ALLEN GOODMAN, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/2/58	22c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	22d. LOCATION (City, town, or county) (State) Hyattsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE R. Danzansky & Sons		ADDRESS 3501 14th St., N.W.	
24a. REC'D BY REGISTRAR JAN 6 1958		24b. REGISTRAR'S SIGNATURE <i>U. H. Hedrick</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

932

Items 1, 2 Film G225 2-10-58 et

CERTIFICATE OF DEATH

00913

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7701 EASTERN AVENUE		d. STREET ADDRESS 7701 EASTERN AVENUE	
3. NAME OF DECEASED (Type or print) First HOPE Middle WINDSOR Last NICHOLS		4. DATE OF DEATH Month JAN. Day 29 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/9/1907
9. AGE (In years last birthday) yrs. 50		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WINDSOR		14. MOTHER'S MAIDEN NAME ANNA HOPE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT ROY NICHOLS		Address 7701 EASTERN AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory obstruction DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma in lungs DUE TO 6+ mo. (c) Carcinoma of breast - left 4 yrs. INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/2/55 , to 1/29/58 , that I last saw the deceased alive on 1/22/58 , and that death occurred at 1:57 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. P. McNeill M.D.		ADDRESS (Street, city or town, state) 7600 Carroll Ave DATE SIGNED 1/30/58	
PHYSICIAN'S NAME (Type) W. P. McNeill		Takoma Park, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 1/31/58	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Ft. Myer, Va.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		24. REC'D BY REGISTRAR Washington, D.C. DATE FEB 4 '58	
24b. REGISTRAR'S SIGNATURE W. P. McNeill			

CERTIFICATE OF DEATH

7-2-1953

NAME OF DECEASED
HARRIS, HENRY

AGE

SEX

1001 EASTERN AVENUE

1001 EASTERN AVENUE

WINDSOR

BOYS

10/10/1907

10/10/1907

1001 EASTERN AVENUE

1001 EASTERN AVENUE

BUREAU V. S.

FEB 4 1953

RECEIVED

933

CERTIFICATE OF DEATH

00914

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Scott	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hilton 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Route #1, RFD	
3. NAME OF DECEASED (Type or print) First Peggy Middle Gertrude Last Nichols		4. DATE OF DEATH Month January Day 29 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 17, 1950
9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry K. Nichols		14. MOTHER'S MAIDEN NAME Mildred Hickam	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypertension & Cardiac arrest DUE TO (b) Cardiac arrest DUE TO (c) Cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 4 yr +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 26, 1958 , to January 29, 1958 , that I last saw the deceased alive on January 29, 1958 , and that death occurred at 10:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/29/58			
ACTUAL SIGNATURE Carlos R. Lombardo M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Carlos R. Lombardo, M. D.			
22a. BURIAL, CREMATION, or TRANSIT Burial - Transit	22b. DATE THEREOF 1/30/58	22c. NAME OF CEMETERY OR CREMATORY Gate City	22d. LOCATION (City, town, or county) (State) Gate City, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE FEB 3 '58	24b. REGISTRAR'S SIGNATURE W. H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, place, and cause of death. The text is mirrored and difficult to read.

RECEIVED
BUREAU V. E.
JAN 3 1958

1/30/58
Baltimore, Maryland

934 CERTIFICATE OF DEATH

Reg. Dist. No.

00915

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Grove				c. LENGTH OF STAY IN 1b 50 Years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Grove				d. STREET ADDRESS Rt. 3 Gaithersburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 3 Gaithersburg				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clifford Middle N. Last Nicholson				4. DATE OF DEATH Month Jan. Day 24 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 13 1888	
9. AGE (In years last birthday) yrs. 69		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Ruben M. Nicholson				14. MOTHER'S MAIDEN NAME Florence E Watkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215.20.8988		17. INFORMANT Mrs. Barbara Nicholson Address Same As 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive heart failure DUE TO Left Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) 5 years						INTERVAL BETWEEN ONSET AND DEATH 1 month 2 yrs 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1940 to January 24, 1958 and last saw the deceased alive on Jan. 23, 1958 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 26 N. Summit Ave. Gaithersburg, Md. DATE SIGNED Jan. 24, 1958							
ACTUAL SIGNATURE Wm. A. Linthicum M.D.				PHYSICIAN'S NAME (Type) William A. Linthicum			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 26 58		22c. NAME OF CEMETERY OR CREMATORY Forrest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gray W. Barber ADDRESS Laytonville. Md.				24a. REC'D BY REGISTRAR DATE JAN 28 '58		24b. REGISTRAR'S SIGNATURE W. H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

viator

0790-2

100

2001-01-01

8551 31 NOV

edition, 2 copies

BUREAU V. S.

JAN 28 1958

RECEIVED

935 CERTIFICATE OF DEATH

Reg. Dist. No. 00916

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6810 Georgia St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WENDELL LOVELESS NIELSON</u>		4. DATE OF DEATH Month Day Year <u>1 15 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 29 1908</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>1 16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Administrative Officer Fed. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Utah</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>BRIAN NIELSON</u>		14. MOTHER'S MAIDEN NAME <u>LOVELESS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>550-05-2972</u>	
17. INFORMANT <u>Wife - Mrs. Elizabeth Nielson</u>		Address <u>H</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>acute coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 1954</u> to <u>3 Jan 1958</u> , that I last saw the deceased alive on <u>3 Jan 1958</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>5029 BETHESDA AVE</u>		DATE SIGNED <u>15 Jan 58</u>	
ACTUAL SIGNATURE <u>Herbert Martyn Jr.</u> M.D.			
PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u>		<u>BETH. MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JAN 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00917

936

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Bethesda	
4. DATE OF DEATH First Ellen Middle Patricia Last O'Brien		5. DATE OF DEATH Month January Day 8 Year 1958	
6. NAME OF DECEASED (Type or print)		7. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
8. SEX Female		9. COLOR OR RACE White	
10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. DATE OF BIRTH June 1, 1940	
12. AGE (In years last birthday) 17 yrs.		13. IF UNDER 1 YEAR: Months 7 Days 7 Hours 7 Min.	
14a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14b. KIND OF BUSINESS OR INDUSTRY - - - - -	
15. BIRTHPLACE (State or foreign country) Washington, D.C.		16. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. FATHER'S NAME James C. O'Brien		18. MOTHER'S MAIDEN NAME Doris Malinka	
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		20. SOCIAL SECURITY NO. None	
21. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
22. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 057.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Meningococcus Meningitis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 minutes 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 7, 1958 , to January 8, 1958 , that I last saw the deceased alive on January 8, 1958 , and that death occurred at 10:10a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/8/58 ACTUAL SIGNATURE Ernest R. Simon M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) ERNEST R. SIMON, M. D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/1958	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, MD		24a. REC'D BY REGISTRAR 13 '58 24b. REGISTRAR'S SIGNATURE W. L. Smith	

CERTIFICATE OF DEATH

See back for instructions

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1910		Baltimore, Md.		Baltimore, Md.		Heart Disease		Home		10:00 AM		J. Smith, M.D.		J. Doe, Registrar	
Occupation		Marital Status		Color		Religion		Education		Social Status		Manner of Death		Burial Place		Burial Date		Burial Time		Burial Signature	
Teacher		Married		White		Catholic		High School		Middle Class		Natural		Catholic Cemetery		Jan 15, 1955		10:00 AM		J. Doe, Registrar	
Date of Death		Time of Death		Place of Death		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Burial		Signature of Burial		Signature of Burial	
Jan 13, 1955		10:00 AM		Home		Heart Disease		Home		10:00 AM		J. Smith, M.D.		J. Doe, Registrar		J. Doe, Registrar		J. Doe, Registrar		J. Doe, Registrar	

BUREAU V. S.

JAN 13 1955

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00918

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Montgomery Co.</u> b. COUNTY <u>Maryland</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>6 Weeks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2300 Blueridge Drive</u>			d. STREET ADDRESS <u>2300 Blueridge Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Anthony OLDERSHAW</u>			4. DATE OF DEATH Month Day Year <u>January 13 19 58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 November 1957</u>		9. AGE (in years last birthday) yrs. <u>1</u> Months <u>16</u> Days <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John B. OLDERSHAW</u>			14. MOTHER'S MAIDEN NAME <u>Carol Bromann</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>(Father) John B. Oldershaw (Same As #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Broncho-Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in Bed</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in Bed</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>20f. (City or town) (County) (State)</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-13-58</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart, MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-17-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u>		22e. LOCATION (State) <u>Virginia</u>		22f. LOCATION (Country) <u>USA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u>		23a. ADDRESS <u>7557 Wisconsin Ave., Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>Jan 14 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Cliff Leach</u>		24c. DATE <u>Jan 14 58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051243XV4

RECEIVED

JAN 14 1958

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 938 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00919

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	c. LENGTH OF STAY IN 1b <u>28 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1701 Lennis Ave</u>		d. STREET ADDRESS <u>1701 Lennis Ave</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>John CARVEL Paine</u>	First <u>CARVEL</u> Middle <u>Paine</u> Last	4. DATE OF DEATH <u>Jan 16 1958</u>	Month <u>Jan</u> Day <u>16</u> Year <u>1958</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-30-1902</u>
9. AGE (in years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>architect</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>John Hopkins Lab.</u>	11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN Nelson Paine</u>	
14. MOTHER'S MAIDEN NAME <u>Essie Jane Dice</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW #2</u>	
16. SOCIAL SECURITY NO. <u>578-10-7674</u>		17. INFORMANT <u>Frances Paine - Same as Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u> <u>976x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>shot gun wound</u> (c) <u></u> DUE TO cause lost (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>self inflicted shot gun wound</u>	
20c. TIME OF INJURY Month, Day, Year <u>1-16 1958</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) <u>Silver Spring Montg md</u> (County) <u></u> (State) <u>md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/20/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u> (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		24a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u></u>	
ADDRESS <u>SILVER SPRING, MD.</u>		DATE <u>JAN 21 58</u>	

BUREAU V. B.

9548

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00920

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Adelaide</u> Last <u>Parkhurst</u>				4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-23-78</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired-hswf.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>John Reinmiller</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Rein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>----</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerosis</u> (c) <u> </u> DUE TO (a) <u> </u> (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PHILADELPHIA, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 16 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 16 1959
BUREAU V. S.

: 939

CERTIFICATE OF DEATH

Reg. Dist. No.

00921

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ohio</u> b. COUNTY <u>Cleveland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cleveland</u> 72 X 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>CATHERINE</u> Middle <u>Barbara</u> Last <u>PAULEY</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1873</u>	
				9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>George Riehn</u>				14. MOTHER'S MAIDEN NAME <u>Mary Reitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mr. Alex Thatt</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CARDIO VASCULAR disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 28</u> , 1955, to <u>JAN 30</u> , 1958, that I last saw the deceased alive on <u>JAN 24</u> , 1958, and that death occurred at <u>6:06 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8025 HEBERDEEN RD</u> DATE SIGNED <u>JAN 30 1958</u>							
ACTUAL SIGNATURE <u>DeWitt E. DeLanter</u>				M.D. <u>8025 HEBERDEEN RD</u>			
PHYSICIAN'S NAME (Type) <u>DeWitt E. DeLanter</u>				<u>Bethesda 14, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Knollwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cleveland Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Haverlin's Sons</u>				ADDRESS <u>1756 Pa. Ave. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 3 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>DeWitt E. DeLanter</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7

BUREAU V. S.

FEB 3 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

940

CERTIFICATE OF DEATH

00922

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 8 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle LODGE Last PAXSON				4. DATE OF DEATH Month JAN. Day 21 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/11/99	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHARMACIST (District Mgr. Peoples Drug)				10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ROBERT SCOTT PAXSON				14. MOTHER'S MAIDEN NAME ANNIE LODGE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW #1 214-03-8235		17. INFORMANT Mrs. Margaret A. Paxson, 4408 Hewitt Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Emboli 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized atherosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 10 hours 4-5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 1936 , to Jan 21 1958 , that I last saw the deceased alive on Jan 21 1958 , and that death occurred at 4:00 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W.B. Wardrop MD M.D.				ADDRESS (Street, city or town, state) 837 Bonfanti St. Silver Spring, Md.			
DATE SIGNED JAN 23 1958							
PHYSICIAN'S NAME (Type) W.B. WARDROP MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/24/58		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Walter B. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JAN 23 1958	
				24b. REGISTRAR'S SIGNATURE Al H. Lewis			

BUREAU V. S.

941

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Glen Echo Heights			
c. LENGTH OF STAY IN 1b 16 yrs.				d. STREET ADDRESS 6409 Dahlonga Rd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6409 Dahlonga Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LUCILLE Middle PELLEU Last PELLEU				4. DATE OF DEATH Month Jan. Day 10, Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 14, 1904	
9. AGE (In years lost birthday) 53 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Anderson, Ind.	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Clarence E. Merryman		14. MOTHER'S MAIDEN NAME Nellie Zion		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Husband George B. Pelleu, Sr.		Address Item #2		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastasis - General 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma - Bronchogenic DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 mos +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 1957 to Jan 10 1958 , that I last saw the deceased alive on Jan 4 1958 , and that death occurred at 7:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1028 Conn Ave NW, Wash 6 D.C. DATE SIGNED Beveridge Miller							
ACTUAL SIGNATURE Beveridge Miller M.D.							
PHYSICIAN'S NAME (Type) BEVERIDGE MILLER M.D. Wash 6 D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-13-58		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert a. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR JAN 13 '58	
24b. REGISTRAR'S SIGNATURE [Signature]							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1958 13 JAN

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

942 CERTIFICATE OF DEATH

00924

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		MARYLAND c. LENGTH OF STAY IN 1b 5 Years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Lutes Lane		d. STREET ADDRESS 5 Lutes Lane		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) EILEEN First Middle Last C PIPER		4. DATE OF DEATH Jan. 15 1958 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Nov. 10 1911		9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most working life) House wife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Oklahoma	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Cristopher Carey		14. MOTHER'S MAIDEN NAME Mc Manchon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. #####		17. INFORMANT George A. Piper, Address Same As 2	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronoid of Liver 581.0 DUE TO Marked Secondary Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Jan 15 1958 , to Jan 15 1958 , that I last saw the deceased alive on Jan 15 1958 , and that death occurred at 9:15 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 934 Ellsworth Dr. Silver Spring Md. DATE SIGNED 1-15-58					
ACTUAL SIGNATURE Kenneth F. Laughlin M.D.					
PHYSICIAN'S NAME (Type) Kenneth F. Laughlin		934 Ellsworth Drive Silver Spring			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 18 1958		22c. NAME OF CEMETERY OR CREMATORY St. Johns	
22d. LOCATION (City, town, or county) Silver Spring		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Groy W. Barber		ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE Jan 15 1958	
24b. REGISTRAR'S SIGNATURE Paul ...					

Keywords: child sexual abuse; disclosure; self-blame

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1. *Journal of Management Studies*, 1997, 34, 1, 1-15.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 6 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1101 DRYDEN STREET		e. STREET ADDRESS 1101 DRYDEN STREET	
3. NAME OF DECEASED (Type or print) ANNA First (NMI) Middle PRIEDITE Last		4. DATE OF DEATH JANUARY 11 Month 11 Day 19 Year 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 13, 1869
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE (retired)		12. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13. BIRTHPLACE (State or foreign country) LATVIA		14. CITIZEN OF WHAT COUNTRY LATVIA	
15. FATHER'S NAME JANIS GOLDBERGS		16. MOTHER'S MAIDEN NAME UNKNOWN	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		18. SOCIAL SECURITY NO. NONE	
19. INFORMANT MRS. REINHOLDS KARKLINS		20. ADDRESS (SPRING, MD. 1101 DRYDEN ST., SILVER)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Found dead in bed 3 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED JAN. 12, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 13, 1958	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey		24a. REC'D BY REGISTRAR JAN 14 '58	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE W. Broschart	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 14 1958

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00926

Reg. Dist. No.

944

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10204 Haywood Dr.</u>			d. STREET ADDRESS <u>10204 Haywood Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Carrie Virginia Pyle</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>15</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-1868</u> 89 yrs.		9. AGE (In years last birthday) <u>89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>	
13. FATHER'S NAME <u>M. Harris</u>			14. MOTHER'S MAIDEN NAME <u>Amelia Newton</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Virginia E. Strobel - Same as Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Jan 15-1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Edgar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Suithland, R 600 Co, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co - Riverdale, MD</u>		ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Deborah</u>
				DATE	

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BUREAU V. S.

945 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Tennessee b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sneadville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Route #1	
3. NAME OF DECEASED (Type or print) First Charles Middle Henry Last Ramsey		4. DATE OF DEATH Month January Day 22 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1924
9. AGE (In years last birthday) 33		10. IF UNDER 1 YEAR Months 33 Days 33 Hours 33 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hugh Ramsey		14. MOTHER'S MAIDEN NAME Donna Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 411-36-5393	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month 19 Day 19 Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 30, 1957 , to January 22, 1958 , that I last saw the deceased alive on January 22, 1958 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Roger Lester		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/22/58	
PHYSICIAN'S NAME (Type) Roger Lester, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 1/25/58	22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	22d. LOCATION (City, town, or county) (State) Greenwood Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE Chung Chase Funeral Home		24a. REC'D BY REGISTRAR DATE JAN 24 '58	
24b. REGISTRAR'S SIGNATURE Reed			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00928

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gaithersburg		c. LENGTH OF STAY IN 1b 10 yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. #1 Gaithersburg, Md.		e. STREET ADDRESS / Rt. #1	
3. NAME OF DECEASED (Type or print) Elijah First (None) Middle Redmon Last		4. DATE OF DEATH Jan. Month 27 Day 19 Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1882? 9. AGE (In years last birthday) 76? yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Redmon		14. MOTHER'S MAIDEN NAME Octavious Redmon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Margaret Burdette Address Rt. #1 Gaithersburg			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure - 420.0 DUE TO Artery + Coronary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart (c) Disease		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 15 , 19 56 , to Jan. 27 , 19 58 , that I last saw the deceased alive on Jan. 14 , 19 58 , and that death occurred at 11:34 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Jack Schumacher M.D.		ADDRESS (Street, city or town, state) 1-29-58	
PHYSICIAN'S NAME (Type) Dr. Jack Schumacher		Medical Arts Bldg. Gaithersburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-58	
22c. NAME OF CEMETERY OR CREMATORY Dickerson Methodist		22d. LOCATION (City, town, or county) (State) Dickerson, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Boyd Barber ADDRESS Laytonville, Md.		24a. REC'D BY REGISTRAR Feb 3 1958 24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 17, Film 225 2-7-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

00929

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>3131 MILITARY RD. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edward George Reinhard</u> First Middle Last				4. DATE OF DEATH <u>January 29 1958</u> Month Day Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 20, 1899</u> 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Biologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH REINHARD</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET SCHMIDT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>459-52-4213</u>		17. INFORMANT <u>Wife</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>"</u> DUE TO <u>"</u> (c) <u>"</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 9</u> , 1958, to <u>Jan 29</u> , 1958, that I last saw the deceased alive on <u>Jan 29</u> , 1958, and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert B. Havell</u> M.D.				ADDRESS (Street, city or town, state) <u>5576 Nebraska Ave</u> DATE SIGNED <u>1-30-58</u>			
PHYSICIAN'S NAME (Type) <u>Robert B. Havell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-1-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE-OF-HEAVEN</u>		22d. LOCATION (City, town, or county) (State) <u>SILVER SPRING, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Cochran</u> ADDRESS <u>3821-14th ST. N.W. D.C.</u>				24a. REC'D BY REGISTRAR <u>Wash.</u> DATE <u>FEB 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Wash.</u>	

RECEIVED

CERTIFICATE OF DEATH

1. NAME OF DECEASED MAYNARD		2. SEX MALE	
3. AGE 21		4. RACE WHITE	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. DATE OF BIRTH JAN 10 1938	
7. PLACE OF DEATH BALTIMORE, MARYLAND		8. DATE OF DEATH JAN 10 1938	
9. TIME OF DEATH 11:00 AM		10. CAUSE OF DEATH HEART DISEASE	
11. MANNER OF DEATH NATURAL		12. SIGNATURE OF PHYSICIAN J. H. HARRIS	
13. SIGNATURE OF REGISTRAR J. H. HARRIS		14. SIGNATURE OF WITNESS J. H. HARRIS	

RECEIVED
JAN 10 1938
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN IB 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ *** Glenelg
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		d. STREET ADDRESS 138-2	
3. NAME OF DECEASED (Type or print) First Morris Middle W. Last Ridgely		4. DATE OF DEATH Month January Day 12 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 4, 1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William H. Ridgely		14. MOTHER'S MAIDEN NAME Ruth J. Ridgely Day	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. ?	
17. INFORMANT hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 420.0 DUE TO Arteriosclerotic heart disease with myocardial insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitis		INTERVAL BETWEEN ONSET AND DEATH 3 days 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 4, 1955 , to Jan. 12, 1958 , that I last saw the deceased alive on Jan. 11, 1958 , and that death occurred at 12:10am , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles S. Whitaker M.D.		1-13-58	
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M. D., Clarksville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-15-58	
22c. NAME OF CEMETERY OR CREMATORY Mt. View		22d. LOCATION (City, town, or county) (State) Alpha, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.		24a. REC'D BY REGISTRAR JAN 15 '58	
24b. REGISTRAR'S SIGNATURE W. H. Beach			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 15 1953

BUREAU V. S.

950 CERTIFICATE OF DEATH

Reg. Dist. No. 00932

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				d. STREET ADDRESS 3000 Briggs Chaney Road			
3. NAME OF DECEASED (Type or print) First Sarah Middle Ellen Last Robey				4. DATE OF DEATH Month January Day 23 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/18/92 81	
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Horace Harrison				14. MOTHER'S MAIDEN NAME Julia Athey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 3132 Briggs Chaney Rd.			
17. INFORMANT Mrs. William E. Lusby Silver Spring							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Congestive Heart Failure 5 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Arteriosclerotic Heart Disease years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1/28/58 , 19 57 , to 1/23/58 , 19 58 , that I last saw the deceased alive on 1/23/58 , 19 58 , and that death occurred at 3000 M, from the causes and on the date stated above. ACTUAL SIGNATURE J. W. Bird M.D. ADDRESS (Street, city or town, state) Sandy Spring, Maryland DATE SIGNED 1/23/58 PHYSICIAN'S NAME (Type) J. W. Bird, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/27/58		22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE UNION CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				24a. REC'D BY REGISTRAR JAN 27 58		24b. REGISTRAR'S SIGNATURE C. W. Jones	

RECEIVED

951 CERTIFICATE OF DEATH

Reg. Dist. No. 00933

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown,				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Poolesville,			
				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LOURETTA Middle SPRING Last ROBINSON				4. DATE OF DEATH Month Jan. Day 1 Year 19 58			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1957		9. AGE (In years last birthday) yrs. 4	IF UNDER 1 YEAR Months 4 Days Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S. A.
13. FATHER'S NAME George C. Robinson				14. MOTHER'S MAIDEN NAME Bertha E. Wims			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT George C. Robinson		Address Poolesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492x DUE TO Pneumonia, atypical Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO 							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. 19 p. m. 	Month Day 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from Dec. 29 , 19 57 , to Jan 1 , 19 58 , that I last saw the deceased alive on Jan 1 , 19 58 , and that death occurred at 10:50 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Germantown, Md. DATE SIGNED 12-58 ACTUAL SIGNATURE Dr. V.E. Martens M.D. PHYSICIAN'S NAME (Type) V.E. Martens md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/5/58	22c. NAME OF CEMETERY OR CREMATORY Poolesville,		22d. LOCATION (City, town, or county) (State) Poolesville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snodden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE JAN 7 '58	24b. REGISTRAR'S SIGNATURE Robert L. Snodden

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

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RECEIVED

952

CERTIFICATE OF DEATH

Reg. Dist. No. 934

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY COLUMBIA ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS NURSING HOME		d. STREET ADDRESS 1214 MADISON ST NW	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NELSON Middle E Last ROSS		4. DATE OF DEATH Month JANUARY Day 6 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 5, 1892
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY WESTERN UNION	11. BIRTHPLACE (State or foreign country) KANSAS
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME NELS ROSS		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-03-7603	
17. INFORMANT GENE ROSS		Address 42 RIDGEWOOD RD WEST HARTFORD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO Serious - age (±) 65 (c) Serious			INTERVAL BETWEEN ONSET AND DEATH 1 wk yr yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 6, 1957 , to 1/6/58 , 19 58 , that I last saw the deceased alive on 1/6/58 , 19 58 , and that death occurred at 5:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kensington, MD DATE SIGNED 1/6/58			
ACTUAL SIGNATURE Joseph E. Sowers M.D.		PHYSICIAN'S NAME (Type) Joseph E. Sowers	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	22b. DATE THEREOF JAN. 7, 1958	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) BUFFALO, N. Y.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph E. Sowers, Wash., D.C.		24a. REC'D BY REGISTRAR DATE JAN 8 '58	24b. REGISTRAR'S SIGNATURE W. E. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AN 8 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00935

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 15 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 508 Mississippi Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BENSON Middle SEYMOUR Last ROWE				4. DATE OF DEATH Month Jan. Day 13 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/2/82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper (retired)		10b. KIND OF BUSINESS OR INDUSTRY Barber & Ross		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John K. Rowe				14. MOTHER'S MAIDEN NAME Ellen R. Barnes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Virginia E. Rowe, 508 Mississippi Ave. Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic coronary disease DUE TO (c) arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: chronic bronchial asthma INTERVAL BETWEEN ONSET AND DEATH: 2 min.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1953 to Jan 13, 1958 , that I last saw the deceased alive on Jan 10, 1958 , and that death occurred at 2 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1319 Seminary Rd. Silver Spring, Md. DATE SIGNED 1-13-58							
ACTUAL SIGNATURE John S. Rogers M.D.							
PHYSICIAN'S NAME (Type) JOHN S. ROGERS							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/15/58		22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey				24a. REC'D BY REGISTRAR DATE JAN 15 '58		24b. REGISTRAR'S SIGNATURE Allen	

BUREAU V. S.

JAN 15 1959

RECEIVED

954

CERTIFICATE OF DEATH

Reg. Dist. No.

00936

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b Kensington d. NAME OF HOSPITAL (If not in hospital, give street address) 4300 Ambler Drive		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 4300 Ambler Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle W. Last RUDERICH		4. DATE OF DEATH Month Jan , Day 26 , Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1888
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 2 Days 8	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret-		10b. KIND OF BUSINESS OR INDUSTRY Red Star Yeast Co.	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Henry Ruderich		14. MOTHER'S MAIDEN NAME Frances Best	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 387-09-6980A	
17. INFORMANT Mary Ruderich-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 450.0 DUE TO Arteriosclerosis - Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 1 week yes yes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1558 (County) (State)
21. I certify that I attended the deceased from Jan 11 1958 to Jan 26 1958 , that I last saw the deceased alive on Jan 26 1958 , and that death occurred at 12:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1/26/58			
ACTUAL SIGNATURE Samuel Allen M.D.		PHYSICIAN'S NAME (Type) Samuel Allen - Kensington, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Transit	22b. DATE THEREOF 1/27/58	22c. NAME OF CEMETERY OR CREMATORY Union	22d. LOCATION (City, town, or county) Milwaukee, Wisconsin (State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 28 '58	24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Robert L. Taylor-Bellamy, Jr.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

955

CERTIFICATE OF DEATH

Reg. Dist. No.

00937

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 10 min			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				47X-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 823 Barnaby Street, S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Baby		First Girl		Last RUMPLIK		4. DATE OF DEATH Month January Day 9 Year 19 58	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 January 1958		9. AGE (In years lost birthday) yrs. 10	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Rudolph Hoover RUMPLIK				14. MOTHER'S MAIDEN NAME Charlotte FITCH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No - -		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Rudolph H. RUMPLIK (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxemia 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prolapse of the Umbilical Cord DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 January , 19 58 , to 9 January , 19 58 , that I last saw the deceased alive on 9 January , 19 58 , and that death occurred at 3:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Kenneth W. Sell M.D. U.S. Naval Hospital, Bethesda, Md. 1-10-58							
ACTUAL SIGNATURE Kenneth W. Sell, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-15-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.				24a. REC'D BY REGISTRAR Jan 13 '58		24b. REGISTRAR'S SIGNATURE Paul...	

2051272X44

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

1358 JAN 13

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

956

CERTIFICATE OF DEATH

00938

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b 10 das			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7709 Meadow Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CORINNA LESUEUR RUSSELL				4. DATE OF DEATH Month January Day 4 Year 19 58			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/30/1882	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
13. FATHER'S NAME Alexander A. Lesueur				12. CITIZEN OF WHAT COUNTRY? U. S.			
14. MOTHER'S MAIDEN NAME Trigg							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Alexander L. Russell, 7709 Meadow Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary embolism 465x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 903.0 fracture of right radius 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fell in own home on level floor					
20c. TIME OF INJURY Hour a. n. 12/23 Day 19 Year 57 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Alexandria, Va.	
21. I certify that I attended the deceased from Nov , 19 49 , to JAN 4 , 19 58 , that I last saw the deceased alive on DEC 24 , 19 58 , and that death occurred at 12:30 P. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1/4/58 DATE SIGNED ACTUAL SIGNATURE Louis Ross M.D. 915 19th St., NW., Washington, DC PHYSICIAN'S NAME (Type) Louis Ross (Montgomery County Coroner notified & approved)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Jan 5-1958		22c. NAME OF CEMETERY OR CREMATORY Sikeston, Mo.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawley's Sons, Wash. DC.				24a. REC'D BY REGISTRAR DATE JAN 8 '58		24b. REGISTRAR'S SIGNATURE W. H. Leach	

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RECEIVED

957

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Mongtomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmor Sanitarium & Hospital 5721 Grosvenor Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eunice Tyree Ryan		4. DATE OF DEATH Month January Day 4 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1874
9. AGE (In years last birthday) 83 yrs.		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Woodson A. Tyree		14. MOTHER'S MAIDEN NAME Mary J. Houston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Records at Resmor Sanitarium & Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Enteric Subacute Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 hours 10 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1 , 19 30 to Jan 4 , 19 58 , that I last saw the deceased alive on Dec 29 , 19 57 , and that death occurred at 8:00 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1746 - K Street N.W. Wash. DC DATE SIGNED 1/4/58			
ACTUAL SIGNATURE William T. Gill		PHYSICIAN'S NAME (Type) WILLIAM T. GILL MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/7/58	22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W.		24a. REC'D BY REGISTRAR JAN 8 '58	24b. REGISTRAR'S SIGNATURE W. H. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00940

Reg. Dist. No.

958

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1601 Coral Sea Dr</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Martha Philomena Saffell</u>				4. DATE OF DEATH Month Day Year <u>Jan 24 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 22, 1925</u>	9. AGE (In years last birthday) <u>32</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John Martinus</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Elmer Saffell (H) 1601 Coral Sea Dr, Rockville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> DUE TO <u>Cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured Aneurysm, Middle Cerebral Artery</u> DUE TO (c) <u>Congenital Berry Aneurysm</u>						INTERVAL BETWEEN ONSET AND DEATH <u>14 hours</u> <u>14 hours</u> <u>33 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>23 Jan., 1958</u> , to <u>24 Jan., 1958</u> , that I last saw the deceased alive on <u>24 Jan., 1958</u> , and that death occurred at <u>8:40 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hermin C. Maganzini</u>				ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd. Rockville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>H. C. Maganzini</u>				DATE SIGNED <u>1/24/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Attest</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

JAN 27 1953

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

959 CERTIFICATE OF DEATH

00941

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>VIRGINIA</u> b. COUNTY <u>ARLINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARLINGTON</u> 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RESMOR SANITARIUM & Hospital</u>		d. STREET ADDRESS <u>2110 N. 16th ST</u>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>PAUL</u> Last <u>SAMPLE</u>		4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 Sept. 1882</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clerk, U.S. Senate</u>	
11. BIRTHPLACE (State or foreign country) <u>Nightstown, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Andrew Sample</u>		14. MOTHER'S MAIDEN NAME <u>Anna Maria Kirk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Charles E. Sample</u>		Address <u>2110-16th St., N., Arlington, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 1957, to <u>January</u> , 1958, that I last saw the deceased alive on <u>January 27</u> , 1958, and that death occurred at <u>12:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Thomas E. Curtin</u>		M.D. <u>900 17th ST N.W.</u>	
PHYSICIAN'S NAME (Type) <u>Thomas E. CURTIN</u>		<u>Washington D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/30/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawyers Smith</u>		24a. REC'D BY REGISTRAR <u>Jan 30 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>		24c. ADDRESS <u>1756 Pennsylvania Ave NW, Washington, DC</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	

CERTIFICATE OF DEATH

00942

Reg. Dist. No.

960

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Kentucky</u> b. COUNTY <u>Warren</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smith's Grove</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>R 4</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>King</u> Last <u>Sanderson</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 22, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>12</u> Hours <u>12</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Robert M. Sanderson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Milton Richardson</u>		Address <u>Smith's Grove, Ky.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombotic infarction</u> DUE TO <u>430.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertension. heart disease</u> (c) <u>1071.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>tetramin congestive heart failure</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>118</u> , 19 <u>58</u> , to <u>1/12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/4</u> , 19 <u>58</u> , and that death occurred at <u>12:29</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>31 Oxford St, C.A. Md.</u> DATE SIGNED <u>John V. Dolan</u>			
ACTUAL SIGNATURE <u>John V. Dolan</u>		PHYSICIAN'S NAME (Type) <u>John V. Dolan</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cane City Cme.</u>		22d. LOCATION (City, town, or county) (State) <u>Cane City Ky.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>		ADDRESS <u>5103 N. 2nd St. Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>William J. Peoples</u>		DATE <u>JAN 26 1958</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

AN 20 1958

RECEIVED

CERTIFICATE OF DEATH

00943

Reg. Dist. No. 215

961

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>1109 5th St. S.E. Apt. 11</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>SCOTT</u>		4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 January 1958</u>
9. AGE (In years lost birthday) yrs. <u>5</u> Months <u>5</u> Days <u>15</u>		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u> IF UNDER 24 HRS. Hours <u>5</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ronald Melvin SCOTT</u>		14. MOTHER'S MAIDEN NAME <u>Muriel Marie BRADLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>(Father) Ronald M. Scott, (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fetal Atelectasis</u> DUE TO (c) <u>Immaturity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval Between Onset and Death</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>21 January, 19 58</u> , to <u>21 January, 19 58</u> , that I last saw the deceased alive on <u>21 January, 19 58</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Adam T. Thorp, Jr.</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>		DATE SIGNED <u>1-23-58</u>	
PHYSICIAN'S NAME (Type) <u>Adam T. Thorp, Jr. LT, MC, USN</u>		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-28-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alexander Pope</u>		24a. REC'D BY REGISTRAR <u>JAN 27 '58</u>	
ADDRESS <u>Alexander Pope, 414 15th St. S.E. Washington, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

2

M

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51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTHS AND DEATHS

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

BUREAU V. S.

JAN 27 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 225 2-3-58 ams

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 00944

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>6415 Lybrook Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Stewart Kendall Scott</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22, 1957</u>
9. AGE (In years last birthday) <u>xxx</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>19</u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert M. Scott</u>		14. MOTHER'S MAIDEN NAME <u>Marion Wheeler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Marion Scott (mother)</u>		Address <u>Same as Itm 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Interstitial pneumonia</u> <u>525X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Jan. 11, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/13/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D C</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. Lawless Sons Inc.</u>		ADDRESS <u>1756 Penna Ave NW Washington</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

2

2

MEDICAL CERTIFICATION

RECEIVED

JAN 14 1938

BUREAU V. 3

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

1. Name of Deceased: _____

2. Age: _____

3. Sex: _____

4. Race: _____

5. Date of Birth: _____

6. Date of Death: _____

7. Place of Death: _____

8. Cause of Death: _____

9. Manner of Death: _____

10. Signature of Medical Examiner: _____

11. Signature of Coroner: _____

12. Signature of Registrar: _____

13. Signature of Physician: _____

14. Signature of Nurse: _____

15. Signature of Undertaker: _____

16. Signature of Burial Society: _____

17. Signature of Cemetery: _____

18. Signature of Funeral Home: _____

19. Signature of Mortician: _____

20. Signature of Embalmer: _____

21. Signature of Crematorium: _____

22. Signature of Interment: _____

23. Signature of Burial: _____

24. Signature of Cremation: _____

25. Signature of Disposition: _____

26. Signature of Final Rest: _____

27. Signature of Final Disposition: _____

28. Signature of Final Disposition: _____

29. Signature of Final Disposition: _____

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100. Signature of Final Disposition: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00945

Reg. Dist. No.

963

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Myrtle Middle Scrivens Last Scrivens		4. DATE OF DEATH Month Jan Day 6 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/8/1875
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Poole		14. MOTHER'S MAIDEN NAME Mary E. Howe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Emilie Scrivens		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334x DUE TO Apoplexy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO Many years (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 10, 1957 , to Jan 6, 1958 , that I last saw the deceased alive on Jan 5, 1958 , and that death occurred at 356A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4016 Georgetown Rd Bethesda 14 Md DATE SIGNED Leo I Donovan			
ACTUAL SIGNATURE Leo I Donovan M.D.		PHYSICIAN'S NAME (Type) LEO I DONOVAN MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/7/58	
22c. NAME OF CEMETERY OR CREMATORY Nat. Mem. Park Cemetery		22d. LOCATION (City, town, or county) (State) Falls Church, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St. N.W.		24a. REC'D BY REGISTRAR JAN 7 '58	
24b. REGISTRAR'S SIGNATURE Overman			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

RECEIVED

BUREAU V. S.

JAN 7 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00946

964

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY IN 1b X KENSINGTON d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11,223 EAST AVENUE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X KENSINGTON d. STREET ADDRESS 11,223 EAST AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle EMADEAN Last SHEPPERD		4. DATE OF DEATH Month JAN. Day 24 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 7, 1919
9. AGE (In years last birthday) 38 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER	11. BIRTHPLACE (State or foreign country) PORTLAND, OREGON
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ARTHUR RAY NELSON	
14. MOTHER'S MAIDEN NAME HELEN JOHNSON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 533-12-1074		17. INFORMANT Address Mr. Irving J. Shepperd, 11,223 East Ave. Kensington, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema due to acute hemorrhagic 587.0 DUE TO sudden Conditions, if any, which gave rise to immediate cause (b) pancreatitis (c) pancreatitis DUE TO pancreatitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) pancreatitis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) FRANK J. BROSCART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1/24/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 1/27/58	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY	22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR JAN 27 '58	24b. REGISTRAR'S SIGNATURE W. E. Humphrey

MAINTAIN STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

BURMAN W.S.

JAN 27 1939

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. No. 100847

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Hawaii</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takona Park</u>		c. LENGTH OF STAY IN 1b <u>8 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7057 Carroll Ave</u>		d. STREET ADDRESS <u>P.O. Box 462</u>	
3. NAME OF DECEASED (Type or print) <u>Fred Ichiro Shimomura</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>yellow</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-1917</u>
9. AGE (in years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hawaii</u>	
11. BIRTHPLACE (State or foreign country) <u>Hawaii</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Kisabura Shimomura</u>		14. MOTHER'S MAIDEN NAME <u>Eli Shimomura</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>568-40-8828</u>	
17. INFORMANT <u>Eli Shimomura (wife)</u>		Address <u>Same as item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-26-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 29, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW DC</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 31 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH BUREAU

RECEIVED

BUREAU OF HEALTH

JAN 31 1958

RECEIVED

965

CERTIFICATE OF DEATH

Reg. Dist. No.

00948

1. PLACE OF DEATH a. COUNTY <u>Mont.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 478-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Nursing Home</u>			d. STREET ADDRESS <u>6631 Western Avenue N W</u>		
3. NAME OF DECEASED (Type or print) First <u>JENNIE</u> Middle <u>GROVES</u> Last <u>SHIPMAN</u>			4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1958</u> 19		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 17, 1873</u>		9. AGE (In years last birthday) <u>84</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Indian Head, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Samuel Groves</u>			14. MOTHER'S MAIDEN NAME <u>Mary Cox</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-05-0012B</u>		17. INFORMANT <u>John B. Shipman</u> Address <u>6631 Western Ave NW Washington, DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis generalized</u> DUE TO (c) <u>Senility - age 82+</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 yr.</u> <u>yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 25, 19</u> , to <u>1/9/58</u> , that I last saw the deceased alive on <u>1/5/58</u> , 19, and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Kensington, MD</u> DATE SIGNED <u>1/9/58</u>					
ACTUAL SIGNATURE <u>Sam Allen</u> M.D.					
PHYSICIAN'S NAME (Type) <u>SAM ALLEN</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D C</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Paulina Sano</u>			24a. REC'D BY REGISTRAR DATE <u>JAN 14 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Albee</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

836

CERTIFICATE OF DEATH

00949

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47 x - 3	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <u>820 Longfellow St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>—</u> Last <u>Sisgold</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. America</u>	
13. FATHER'S NAME <u>Benny Sisgold</u>		14. MOTHER'S MAIDEN NAME <u>Sharon (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>154x</u> <u>Myocardial infarction</u> DUE TO <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u>—</u> (c) <u>Terminal cachexia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 mos</u> <u>1 yr.</u> <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 7, 1951</u> to <u>Jan 18, 1958</u> , that I last saw the deceased alive on <u>Jan 18, 1958</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Kenneth Laughlin</u> M.D.		ADDRESS (Street, city or town, state) <u>934 Ellsworth St. Silver Spring, Md.</u>	
DATE SIGNED <u>1-18-58</u>		PHYSICIAN'S NAME (Type) <u>KENNETH LAUGHLIN</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 19, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Ramsey & Son</u> ADDRESS <u>3501-14 St N.W.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JAN 21 '58</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF INTERMENT	
10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CLERK	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF CORONER	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF COUNTY CLERK		21. SIGNATURE OF TOWNSHIP CLERK	
22. SIGNATURE OF VILLAGE CLERK		23. SIGNATURE OF POSTMASTER		24. SIGNATURE OF SCHOOL COMMISSIONER	
25. SIGNATURE OF CHURCH CLERK		26. SIGNATURE OF MINISTERS		27. SIGNATURE OF RABBIS	
28. SIGNATURE OF OTHER CLERGY		29. SIGNATURE OF OTHER OFFICIALS		30. SIGNATURE OF OTHER PERSONS	
31. SIGNATURE OF OTHER PERSONS		32. SIGNATURE OF OTHER PERSONS		33. SIGNATURE OF OTHER PERSONS	
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52. SIGNATURE OF OTHER PERSONS		53. SIGNATURE OF OTHER PERSONS		54. SIGNATURE OF OTHER PERSONS	
55. SIGNATURE OF OTHER PERSONS		56. SIGNATURE OF OTHER PERSONS		57. SIGNATURE OF OTHER PERSONS	
58. SIGNATURE OF OTHER PERSONS		59. SIGNATURE OF OTHER PERSONS		60. SIGNATURE OF OTHER PERSONS	
61. SIGNATURE OF OTHER PERSONS		62. SIGNATURE OF OTHER PERSONS		63. SIGNATURE OF OTHER PERSONS	
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97. SIGNATURE OF OTHER PERSONS		98. SIGNATURE OF OTHER PERSONS		99. SIGNATURE OF OTHER PERSONS	
100. SIGNATURE OF OTHER PERSONS		101. SIGNATURE OF OTHER PERSONS		102. SIGNATURE OF OTHER PERSONS	

BUREAU V. S.

JAN 21 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

837

CERTIFICATE OF DEATH

00950

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Wheaton Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>2012 Henderson Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. George Henry Skinner</u>				4. DATE OF DEATH Month Day Year <u>1 26 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-12-05</u>	
9. AGE (In years last birthday) yrs. <u>52</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>26 19 58</u>		IF UNDER 24 HRS. <u>52</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>							
13. FATHER'S NAME <u>Ernest L. Skinner</u>				14. MOTHER'S MAIDEN NAME <u>Della Mae ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>578-05-2749</u>		17. INFORMANT <u>Chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Cardiac Failure Terminating in Atrial Fibrillation</u> DUE TO (b) <u>Myocardial Infarction Posterior Septal</u> DUE TO (c) <u>Thrombosis Rt. Coronary artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 months</u> <u>2 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Infarction Left due to Pulmonary Embolus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May</u> , 1955, to <u>Jan. 26</u> , 1958, that I last saw the deceased alive on <u>Jan. 26</u> , 1958, and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Jamesa. Roberts</u> M.D. <u>8907 Georgia Ave. Silver Spring Md. JAN. 26, 1958</u>							
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wanner G. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 29 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V.

1958 29 14N

RECEIVED

966

CERTIFICATE OF DEATH

Reg. Dist. No. 00951

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2626 Colston Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM (nmi) Middle SLINEY Last		4. DATE OF DEATH Month January Day 1 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/77
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months 1 Days 18	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Patrick Sliney	
14. MOTHER'S MAIDEN NAME Margaret Murry		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Howard Bernstein-Item# 2		17. INFORMANT Howard Bernstein-Item# 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, General DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 1 yr. 10 yrs(?)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from FEB. , 19 56 to JAN. 1 , 19 58 , that I last saw the deceased alive on DEC 31 , 19 57 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo M. Curtis		ADDRESS (Street, city or town, state) 8218 Wisconsin Ave Bethesda Md.	
PHYSICIAN'S NAME (Type) Leo M. Curtis		DATE SIGNED 1/1/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. - Translt	22b. DATE THEREOF 1/1/57	22c. NAME OF CEMETERY OR CREMATORY St. Josephs	22d. LOCATION (City, town, or county) (State) Columbus, Ohio
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR JAN 6 1958	
24b. REGISTRAR'S SIGNATURE W. Meduch			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Wang et al.

1. $\mathcal{H}^1(\mathbb{R}^n)$ is a Banach space.

1111

BUREAU V. S.

JAN 6 1973

RECEIVED

967

CERTIFICATE OF DEATH

Reg. Dist. No.

00952

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write Bethesda) RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write Bethesda) RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7006 Exeter Road		d. STREET ADDRESS 7006 Exeter Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MRS Edna G. Smith		4. DATE OF DEATH JAN 31 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/85
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months 9 Days 19	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas Jefferson Adams		14. MOTHER'S MAIDEN NAME Mary Jane Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Russell A. Smith-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive heart disease M II DUE TO (c) 15 yrs			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1957 to 31 June 1958 , that I last saw the deceased alive on 29 June 1958 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert Martin Jr M.D.		ADDRESS (Street, city or town, state) 5029 Bethesda Ave	
PHYSICIAN'S NAME (Type) HERBERT MARTIN JR		DATE SIGNED Beth. Md 31 June 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Transit	22b. DATE THEREOF 1/31/58	22c. NAME OF CEMETERY OR CREMATORY Sunset	22d. LOCATION (City, town, or county) (State) Christiansburg, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR Feb 1 1958	24b. REGISTRAR'S SIGNATURE W. E. Smith

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

File Date 19

Name of Deceased Robert A. Thompson, Bethesda, Maryland		Sex Male		Age 38	
Date of Death February 3, 1933		Place of Death Bethesda, Maryland		Cause of Death Heart Disease	
Occupation Physician		Usual Residence Bethesda, Maryland		Place of Birth Maryland	
Married Yes		Spouse's Name Mary Jane Jones		Spouse's Address Bethesda, Maryland	
Burial Place Bethesda, Maryland		Funeral Home Thompson & Sons, Baltimore		Physician's Signature Robert A. Thompson	
Registrar's Signature John D. Smith		Date of Registration February 3, 1933		Place of Registration Baltimore, Maryland	

BUREAU V. S.

FEB 3 1933

RECEIVED

838

CERTIFICATE OF DEATH

Reg. Dist. No.

00953

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12koma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>9109 Colesville Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>John Douglas Smith</u>				4. DATE OF DEATH <u>1-24-58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-4-76</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR <u>81</u> Months		IF UNDER 24 HRS. <u>81</u> Days		Hours <u>81</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher (RETIRED)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>America</u>	
13. FATHER'S NAME <u>Alexander D. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mary Feeney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-26-0174</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis & Intestinal Obstruction and gangrene small bowel</u> 561.0 DUE TO <u>Postoperative strangulated hernia inguinal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>7 days</u> (c) <u>7 days</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 23</u> , 19 <u>58</u> , to <u>Jan 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 23</u> , 19 <u>58</u> , and that death occurred at <u>12:00</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard A. Fitzgerald</u>				ADDRESS (Street, city or town, state) <u>217 University Blvd E</u>			
PHYSICIAN'S NAME (Type) <u>Silver Spring, Md.</u>				DATE SIGNED <u>1-24-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-28-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>				ADDRESS <u>3821-4th. NW Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 27 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Overman</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1001 1001

Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

JAN 27 1958

RECEIVED

968

CERTIFICATE OF DEATH

Reg. Dist. No.

00954

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> o. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lincoln Ave., Rockville.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lincoln Ave., Rockville, 26</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Lincoln Ave., Rockville, 1</i>	
3. NAME OF DECEASED (Type or print) <i>Lawrence</i> First <i>Smith</i> Middle <i>Smith</i> Last		4. DATE OF DEATH Month <i>1</i> Day <i>21</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 20, 1877</i>
9. AGE (In years last birthday) <i>80 1/2</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TANITOR</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Samuel Smith</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Cooper</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>219056574</i>	
17. INFORMANT <i>Grand-daughter</i>		Address <i>Lincoln Ave., Rockville</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Gastric Carcinoma, inoperable</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 1957</i> to <i>Jan. 21, 1958</i> , that I last saw the deceased alive on <i>Jan. 20, 1958</i> , and that death occurred at <i>4:55 P.</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Clive E. Jackson, M.D. RDI, Gaithersburg, Md. 1-22-58</i>			
ACTUAL SIGNATURE <i>Clive E. Jackson</i>		PHYSICIAN'S NAME (Type) <i>Robert L. Snowden</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/25/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Pleasant View.</i>		22d. LOCATION (City, town, or county) (State) <i>Quince Orchard, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 27 '58</i>	
ADDRESS <i>Rockville, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Quince Orchard</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Ord. No.

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CLERK	
JAMES H. HARRIS		Male		45		Jan 15 1893		Baltimore, Md.		Carpenter		Heart Disease		Baltimore, Md.		10:30 AM		J. H. Harris		J. H. Harris		J. H. Harris	
13. PLACE OF INTERMENT		14. NAME OF INTERMENT		15. DATE OF INTERMENT		16. NAME OF MINISTER		17. NAME OF CLERGYMAN		18. NAME OF CHURCH		19. NAME OF CEMETERY		20. NAME OF FUNERAL HOME		21. NAME OF FUNERAL HOME		22. NAME OF FUNERAL HOME		23. NAME OF FUNERAL HOME		24. NAME OF FUNERAL HOME	
St. Paul's Church		St. Paul's Church		Jan 20 1938		Rev. J. H. Harris		Rev. J. H. Harris		St. Paul's Church		St. Paul's Church		St. Paul's Church		St. Paul's Church		St. Paul's Church		St. Paul's Church		St. Paul's Church	

BUREAU V. 5

JAN 27 1938

RECEIVED

969

CERTIFICATE OF DEATH

00955

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 32 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3217 Connecticut Avenue, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle (none) Last South				4. DATE OF DEATH Month January Day 20 , Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1881		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles S. Turnbull				14. MOTHER'S MAIDEN NAME Elizabeth Claxton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Atherosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 days 14 days 5 yrs. or more							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 19, 1957 , to January 20, 1958 , that I last saw the deceased alive on January 20, 1958 , and that death occurred at 2:51 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE N. Raphael Shulman M.D.				ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 1/21/58	
PHYSICIAN'S NAME (Type) N. Raphael Shulman, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/24/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS 1400 Chapin St NW Washington, DC		24a. REC'D BY REGISTRAR JAN 23 '58	
				24b. REGISTRAR'S SIGNATURE Quiles			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

1. PLACE OF DEATH		2. COUNTY	
3. CITY OR TOWN		4. STATE	
5. DATE OF DEATH		6. TIME OF DEATH	
7. PLACE OF BIRTH		8. AGE	
9. SEX		10. RACE	
11. OCCUPATION		12. CAUSE OF DEATH	
13. MANNER OF DEATH		14. SIGNATURE OF DECEASED	
15. SIGNATURE OF WITNESSES		16. SIGNATURE OF PHYSICIAN	
17. SIGNATURE OF CLERK		18. SIGNATURE OF REGISTRAR	

BUREAU V. 81

JAN 23 1958

RECEIVED

970

CERTIFICATE OF DEATH

Reg. Dist. No. 215

00956

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 9 Hr. 45 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Deborah Middle Lynn Last SOWELL				4. DATE OF DEATH Month January Day 21 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 January 1958		9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	IF UNDER 24 HRS. Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Richard David SOWELL, Jr.				14. MOTHER'S MAIDEN NAME Lois Grimm			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Father) Richard D. Sowell (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fetal Atelecasis (c) Immaturity							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 January, 19 58 to 21 January, 19 58 , that I last saw the deceased alive on 21 January, 19 58 , and that death occurred at 5:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Adam G. Thorp, Jr.				ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 1-21-58			
PHYSICIAN'S NAME (Type) Adam G. Thorp, Jr. LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-22-58		22c. NAME OF CEMETERY OR CREMATORY U.S. Naval Academy Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Taylor Funeral Home, Annapolis, Maryland				24a. REC'D BY REGISTRAR DATA 2 3 '58		24b. REGISTRAR'S SIGNATURE Deborah	

2063263XV1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
JAN 23 1958
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

971

CERTIFICATE OF DEATH

Reg. Dist. No.

00957

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 6 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1225 Woodside Parkway				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Airy 06X-2 ✓			
f. STREET ADDRESS Park Avenue				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mollie Buxton Spurrier Middle Last				4. DATE OF DEATH Month January Day 26 Year 19 58			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1875	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Plane #4 Mt. Airy, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Thomas Buxton				14. MOTHER'S MAIDEN NAME Sarah Brengle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Blanche S. Marsh, 1225 Woodside Pkwy., SS., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic myocarditis with mild failure 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last: (b) Generalized metastatic carcinomatosis origin un- (determined) (c) Residual left hemiplegia Est. 17 yrs. Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 5 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 DEC , 19 57 , to 26 JAN. , 19 58 , that I last saw the deceased alive on 26 JAN. , 19 58 , and that death occurred at 4:24 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Marshall Cuvillier, Jr. M.D.				ADDRESS (Street, city or town, state) 1407 Woodside Parkway, Silver Spring, Maryland		DATE SIGNED 1/26/58	
PHYSICIAN'S NAME (Type) L. Marshall Cuvillier, Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 28, 1958		22c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Airy, Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wenore G. Rumpsey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE JAN 28 '58	
				24b. REGISTRAR'S SIGNATURE Al. Beach			

CERTIFICATE OF DEATH

Reg. No. 111

Name of Deceased		Date of Death	
John Doe		Jan 28, 1959	
Age		Sex	
65		Male	
Race		Marital Status	
White		Married	
Place of Birth		Usual Residence	
New York, N.Y.		123 Main St., Baltimore, Md.	
Cause of Death		Immediate Cause	
Heart Disease		Myocardial Infarction	
Contributing Cause		Hypertension	
Manner of Death		Occupation	
Natural		Teacher	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

RECEIVED
JAN 29 1959
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

839

Item 9 Film G225 2-10-58 et

CERTIFICATE OF DEATH

00958

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>X Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>9401 Corsica Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stella Hazzelett Steinhauer</u>				4. DATE OF DEATH Month Day Year <u>Jan. 26 1958</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-15-88</u>	
9. AGE (In years last birthday) <u>69 1/2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>3 11</u>		IF UNDER 24 HRS. <u>69 1/2</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>			
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edwin Hazel</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Bolan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Medical Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Hypertensive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>about 8 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>DECEMBER 1945</u> , to <u>JAN 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JAN 26</u> , 19 <u>58</u> , and that death occurred at <u>10:35 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7733 BRASKA AVE N.W. WASH DC</u> DATE SIGNED <u>JAN 26 1958</u> ACTUAL SIGNATURE <u>Robert L. Krichmar</u> M.D. PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR WASHINGTON 12 D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>1/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>McKean Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>McKean County, Pennsylv.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JAN 28 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>							

BUREAU V.

JAN 28 1953

RECEIVED

972

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) Suburban Hosp.				d. STREET ADDRESS 4413 Everett St.			
3. NAME OF DECEASED (Type or print) First Zella Middle Gaines Last Summers				4. DATE OF DEATH Month Jan Day 14 Year 1958			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1892		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 10 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Oakdale, Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eli McGill				14. MOTHER'S MAIDEN NAME Lou Reid			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT same Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROSIS GENERALIZED DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 weeks 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. p. m. Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/31 , 19 55 , to JAN 14 , 19 58 , that I last saw the deceased alive on JAN 13 , 19 58 , and that death occurred at 2:02 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard H. Spire				ADDRESS (Street, city or town, state) 4601 16th St NW Wash DC DATE SIGNED 1/14/58			
PHYSICIAN'S NAME (Type) RICHARD H. SPIRE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/17/58		22c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery		22d. LOCATION (City, town, or county) (State) Oakdale, Tenn	
23. FUNERAL DIRECTOR'S SIGNATURE See Funeral Home ADDRESS 300 4th NE, Wash. DC				24a. REC'D BY REGISTRAR DATE JAN 16 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased: *William J. ...*
 Date of Death: *April 13, 1958*
 Place of Death: *Home*
 Cause of Death: *Heart Disease*
 Age: *68*
 Sex: *Male*
 Race: *White*
 Marital Status: *Married*
 Occupation: *Teacher*
 Signature of Physician: *[Signature]*
 Signature of Registrar: *[Signature]*
 Date of Registration: *April 15, 1958*
 Place of Registration: *Baltimore*

BUREAU V. 1

JAN 16 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 FilmG225 2-3-58 et

CERTIFICATE OF DEATH

973

Reg. Dist. No.

00960

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairland Nursing Home		d. STREET ADDRESS 2800 Quebec St. N.W. Apt 1218	
3. NAME OF DECEASED (Type or print) First Eva Middle E Last Talbot		4. DATE OF DEATH Month January Day 26 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/1883
9. AGE (In years last birthday) yrs. 74		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rubin Looms		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Marion L. Peritz		Address daughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Auricular Fibrillation DUE TO (c) Hypertensive heart disease			INTERVAL BETWEEN ONSET AND DEATH 10 minutes years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1955 , to Jan 26 1958 , that I last saw the deceased alive on Jan. 21 1958 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Jerome J. Krick M.D. 2800 Quebec Street, N.W. PHYSICIAN'S NAME (Type) Jerome J. Krick, 2800 Quebec St. N.W., Washington, D.C.			
22a. BURIAL OR CREMATION REMOVAL (Specify)	22b. DATE THEREOF 1/29/58	22c. NAME OF CEMETERY OR CREMATORY Batavia Cemetery	22d. LOCATION (City, town, or county) (State) Batavia, New York
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR DATE JAN 28 '58	24b. REGISTRAR'S SIGNATURE Paul

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CITY

STATE

COUNTY

DECEASED

AGE

SEX

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DECEASED'S RESIDENCE

DATE

TIME

PLACE

CAUSE

EFFECT

REMARKS

SIGNATURE

DATE

PLACE

CAUSE

EFFECT

REMARKS

BUREAU V. B.

JAN 28 1938

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

974

CERTIFICATE OF DEATH

Reg. Dist. No.

00961

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville, Rural				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown, Rural			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) JOE EARLY TAYLOR				4. DATE OF DEATH JANUARY 22 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 12, 1957	
9. AGE (In years lost birthday) yrs. 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph E. Tayler				14. MOTHER'S MAIDEN NAME Catherine Lawson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Joseph Tayler, Germantown, R.F.D. 1—Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, BRONCHIAL 772.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malnutrition DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 days 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV. 12, 1957 , to 19 Jan., 1958 , that I last saw the deceased alive on 19 Jan., 1958 , and that death occurred at 6 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Danversville DATE SIGNED P.O. Boyd, Md.							
ACTUAL SIGNATURE John C. Fawcett		M.D. Danversville					
PHYSICIAN'S NAME (Type) JOHN C. FAWCETT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/58		22c. NAME OF CEMETERY OR CREMATORY Montgomery		22d. LOCATION (City, town, or county) (State) Bearsville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Wilson		ADDRESS Bearsville, Md		24a. REC'D BY REGISTRAR Al Beach		24b. REGISTRAR'S SIGNATURE Al Beach	

2000171XV3

JAN 24 1958

BUREAU V. S.

RECEIVED

975

CERTIFICATE OF DEATH

00962

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Florida</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NMMC, Bethesda Md.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencove Springs</u> <u>48 X-3</u>			
f. STREET ADDRESS <u>114 "A" Street Orion Rd.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Suellen</u> Middle <u>(n)</u> Last <u>THONET</u>				4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8 February 1957</u>	
9. AGE (In years last birthday) yrs. <u>11</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Darrell Owen THONET</u>				14. MOTHER'S MAIDEN NAME <u>Marise Elaine KELLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>(Father) THONET Darrell Owen (Same as #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>14 January</u> , 19 <u>58</u> , to <u>27 January</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>27 January</u> , 19 <u>58</u> , and that death occurred at <u>11:20 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda Md.</u> DATE SIGNED <u>1-27-58</u>							
ACTUAL SIGNATURE <u>Kenneth W. Sell</u> M.D. <u>U.S. Naval Hospital, Bethesda Md.</u>							
PHYSICIAN'S NAME (Type) <u>Kenneth W. SELL, LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-30-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Private Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Gainsville Florida</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>R.A. Pumphrey 7557 Wisconsin Ave. Bethesda Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Deborah</u>	
DATE <u>JAN 30 '58</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9VVVVVVVVXVV

BUREAU V. S.

JAN 30 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
1
FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00963

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>	
		f. STREET ADDRESS	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sally L. Toole</u>		4. DATE OF DEATH <u>Jan 31 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-85</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		12. KIND OF BUSINESS OR INDUSTRY <u>same</u>	
13. FATHER'S NAME <u>Berny Robey</u>		14. MOTHER'S MAIDEN NAME <u>Marian Burton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>5605 Chy etan Pkw.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>1st 2nd & 3rd degree burn involving 90% body, head & extremities</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		18. INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Clothing caught afire while burning trash</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>1/31 1958</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Burtonsville</u> (County) <u>Monty</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 3, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) <u>Burtonsville</u> (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Canaldorn</u>		24a. REC'D BY REGISTRAR <u>FEB 6 '58</u>	
ADDRESS <u>Laurel, Md</u>		24b. REGISTRAR'S SIGNATURE <u>De Witt Canaldorn</u>	

BUREAU V. 3.

FEB. 6 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

977

CERTIFICATE OF DEATH

00964

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilkes-Barre 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 754 Lehigh Street	
3. NAME OF DECEASED (Type or print) First Victor Middle John Last TUNILA		4. DATE OF DEATH Month January Day 4 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 September 1935
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John TUNILA		14. MOTHER'S MAIDEN NAME Viola (Last Name Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1-28-53 to 1-4-58		16. SOCIAL SECURITY NO. 188 28 4132	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Lymphatic Leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 Sept. , 19 57 , to 4 January , 19 58 , that I last saw the deceased alive on 4 January , 19 58 , and that death occurred at 6:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 1-6-58			
ACTUAL SIGNATURE T.S. Dunn, Jr.		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) T.S. DUNN, JR., LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-9-58	22c. NAME OF CEMETERY OR CREMATORY Holy Trinity Cemetery	22d. LOCATION (City, town, or county) (State) Bear Creek, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE Chambers Funeral Home, 1400 Chapin Street, N.W.		24a. REC'D BY REGISTRAR DATE 1-6-58	24b. REGISTRAR'S SIGNATURE Alfred

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1888		BALTIMORE		BALTIMORE		MARYLAND	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1910		BALTIMORE		BALTIMORE		MARYLAND		1958		BALTIMORE		BALTIMORE	
OCCUPATION		DATE		PLACE		CITY		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH	
LABORER		1958		BALTIMORE		BALTIMORE		MARYLAND		HEART DISEASE		NATURAL		1958	
EDUCATION		DATE		PLACE		CITY		COUNTRY		SIGNATURE OF PHYSICIAN		DATE		PLACE	
HIGH SCHOOL		1905		BALTIMORE		BALTIMORE		MARYLAND		J. H. HARRIS		1958		BALTIMORE	
RELIGION		DATE		PLACE		CITY		COUNTRY		SIGNATURE OF REGISTRAR		DATE		PLACE	
METHODIST		1910		BALTIMORE		BALTIMORE		MARYLAND		J. H. HARRIS		1958		BALTIMORE	

BUREAU V. 3

JAN 13 1958

RECEIVED

978

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Th...			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 5513 Parkland Court, S. E.			
3. NAME OF DECEASED (Type or print) First George Middle Myran Last Ugrinic				4. DATE OF DEATH Month January Day 20 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 4, 1918	
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months 16 Days X Hours 2 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Geologist		10b. KIND OF BUSINESS OR INDUSTRY Geology (Government)	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Alex Ugrinic		14. MOTHER'S MAIDEN NAME Mary Capetonovich	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) Yes		(If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 284-03-9095		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Brain Tumor L. Frontal lobe (G. Glomer) DUE TO (c) 6-7 yrs.						INTERVAL BETWEEN ONSET AND DEATH 10 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from January 13, 1958 , to January 20, 1958 , that I last saw the deceased alive on January 20, 1958 , and that death occurred at 9:16 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/21/58 ACTUAL SIGNATURE Robert E. Edgar M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Robert E. Edgar, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-1958		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Va	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Edgar				ADDRESS 131 11th S E		24a. REC'D BY REGISTRAR Jan 23 '58	
				24b. REGISTRAR'S SIGNATURE Carl			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: John Doe
2. Sex: Male
3. Age: 45
4. Date of death: Jan 15, 1938
5. Place of death: Home
6. Cause of death: Heart Disease
7. Signature of physician: Dr. J. Smith
8. Signature of registrar: John Doe
9. Date of registration: Jan 15, 1938

10. Name of informant: John Doe
11. Address of informant: 123 Main St
12. Signature of informant: John Doe
13. Date of completion: Jan 15, 1938

RECEIVED

BUREAU V. B.

JAN 28 1938

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00966

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo			c. LENGTH OF STAY IN 1b X Glen Echo		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6623 Kammork Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) KATHARINE UMSTOT			4. DATE OF DEATH Jan 30 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1885		9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Benno Knoll			14. MOTHER'S MAIDEN NAME Mary Meyer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or not unknown) No		16. SOCIAL SECURITY NO. ---	17. INFORMANT Mrs Wm. N. Ruby-Item# 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sudden DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschatt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-31-58	
EXAMINER'S NAME (Type) Frank J. Broschatt		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bar-Transit		22b. DATE THEREOF 2/1/58		22c. NAME OF CEMETERY OR CREMATORY Hill Crest	
22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Feb 2 1958	
				24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S. X

3 1053

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 00967

980

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. STREET ADDRESS 9302 Jesup Lane	
3. NAME OF DECEASED (Type or print) First Felix Middle Francis Last Vaun		4. DATE OF DEATH Month January Day 14 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20 1916
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		10b. KIND OF BUSINESS OR INDUSTRY R.E. Darling Co.	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vaitekunas		14. MOTHER'S MAIDEN NAME Amelia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. II		16. SOCIAL SECURITY NO. 377-40-8968	
17. INFORMANT Wife		Address 9302 Jesup La. Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO (b) Acute coronary heart failure DUE TO (c) Esophageal - gastric junction - pleural fistula Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 7 days 6 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Esophageal - gastric junction - pleural fistula		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 5, 1957 , to Jan 14, 1958 , that I last saw the deceased alive on 1-14 , 19 58 , and that death occurred at 10:35 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert G. Brewer M.D.		ADDRESS (Street, city or town, state) 8218 Wisconsin Ave Bethesda 14, Md.	
DATE SIGNED Jan 16 '58		24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 17, 1958	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

00968

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>26</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>101 E. Jefferson Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>W</u> Last <u>VINSON</u>		4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 12, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drugist-owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John T. Vinson</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Prout</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Judge T. Anderson-W. Montg. Ave. Rockville</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>severe arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1928</u> , 19____, to <u>January 16, 1958</u> , that I last saw the deceased alive on <u>Jan 15, 1958</u> , and that death occurred at <u>8 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>26 N. Summit Ave. Bethesda, Md.</u> DATE SIGNED <u>1/16/58</u> ACTUAL SIGNATURE <u>Wm. A. Linthicum</u> M.D. <u>Wm. A. Linthicum</u> PHYSICIAN'S NAME (Type) <u>Wm. A. Linthicum</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 18, 58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey,</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. A. Linthicum</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	

BUREAU V. S.

JAN 21 1933

RECEIVED

16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF CORONER	
19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF MORTUARY		21. SIGNATURE OF BURIAL	
22. SIGNATURE OF INTERMENT		23. SIGNATURE OF FUNERAL HOME		24. SIGNATURE OF CEMETERY	
25. SIGNATURE OF CHURCH		26. SIGNATURE OF MINISTERS		27. SIGNATURE OF OTHERS	

CERTIFICATE OF DEATH

00969

Reg. Dist. No.

981

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda,</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City</u> 16x-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>3714 - 41st Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Bernard</u> Last <u>Wagoner</u>				4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 9, 1878</u>	
				9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman Virginia paper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
13. FATHER'S NAME <u>John Thomas Wagoner</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Poole</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT <u>John B. Wagoner, Jr.</u> Address <u>7020 Armat Drive Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> (c) <u>Carcinoma Stomach</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> to <u>Jan</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 7</u> , 19 <u>58</u> , and that death occurred at <u>1:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Robert S. Jayler</u> M.D. <u>Washington Clinic</u> PHYSICIAN'S NAME (Type) <u>Washington D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u>				24. REG'D BY REGISTRAR <u>2901 14th St. N. Washington, D.C.</u>		25. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JAN 10 1963

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00970

982

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sewell's Maternity Hospital				e. STREET ADDRESS Norbeck Rt. 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Baby Vivian Walker				4. DATE OF DEATH January 16 19 58			
5. SEX female	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 16, 58		9. AGE (In years last birthday) yrs. 0 0 1		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Premature				10b. KIND OF BUSINESS OR INDUSTRY Maryland Sewell's Maternity Hosp.		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Charles Walker				14. MOTHER'S MAIDEN NAME Vivian S. Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT mother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atalectasis Failure of respiration DUE TO Premature accidental ruptured Membranes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (c) Prematurity							INTERVAL BETWEEN ONSET AND DEATH 7:30AM Jan. 15
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 16, 1958 , to Jan. 16, 1958 , that I last saw the deceased alive on Jan. 16, 1958 , and that death occurred at 6:30PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Webster Sewell M.D.				ADDRESS (Street, city or town, state) Silver Spring Md			
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.				DATE SIGNED 1/17/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/18/58		22c. NAME OF CEMETERY OR CREMATORY Good Hope,		22d. LOCATION (City, town, or county) (State) Colesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Shorden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR JAN 20 '58	
						24b. REGISTRAR'S SIGNATURE W. Leach	

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CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CITY	
HOSPITAL		PHYSICIAN		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE		SYMPTOMS	
PREVIOUS ILLNESS		TREATMENT		POST-MORTEM	
FAMILY HISTORY		SOCIAL HISTORY		OCCUPATION	
EDUCATION		RELIGION		MARRIAGE	
CHILDREN		SIBLINGS		PARENTS	
GRANDPARENTS		AUNT/UNCLES		COUSINS	
BROTHERS		SISTERS		NEPHEWS	
NIECES		FATHER		MOTHER	
SPOUSE		CHILDREN		GRANDCHILDREN	
OTHER RELATIVES		FRIENDS		ACQUAINTANCES	
WITNESSES		CORONER		BURIAL	
INTERVIEW		FOLLOW-UP		REMARKS	

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JAN 20 1958
BUREAU V. S.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00971

983

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> Henry Canfield Walker MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>Poolesville</u>	
		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Canfield Walker</u>		4. DATE OF DEATH Month Day Year <u>Jan 21, 1958</u> <u>19</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/15/1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Walker</u>		14. MOTHER'S MAIDEN NAME <u>Julia E. Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Emma V. Adams</u>		Address <u>3387 Milwaukee Street Pittsburg, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Jan. 24, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elijah,</u>	22d. LOCATION (City, town, or county) (State) <u>Poolesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overseer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 29 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00972**

984

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>15 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Dayton</u> <u>13X-7</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>Joseph</u> Last <u>Walker</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>6</u> , Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/27/1887</u>		9. AGE (In years last birthday) <u>70</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>stone mason</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Walker</u>				14. MOTHER'S MAIDEN NAME <u>Lula A. Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Linda E. Allnutt, Washington Grove, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Broncho pneumonia</u> <u>903.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of left hip.</u> (c) <u>12/21/57</u> (a), stating the underlying cause last. DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on street</u>					
20c. TIME OF INJURY Month, Day, Year <u>12/21/57</u> <u>4:15 A.M.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) (County) (State) <u>Gaithersburg Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1/6/58</u>			
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 9, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Providence (Meth.)</u>		22d. LOCATION (City, town, or county) (State) <u>Howard, County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Royce Barber</u>				ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 9 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Paul Smith</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the files of the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

50

1967

BUREAU 18

JAN 9 1968

RECEIVED

Providence (North)

Providence, R.I.

985

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase 16</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>4812 Western Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Russell</u> ^{First} <u>Warner</u> ^{Middle} <u>g</u> ^{Last}				4. DATE OF DEATH <u>Jan</u> ^{Month} <u>7</u> ^{Day} <u>1958</u> ^{Year}			
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 10, 1898</u>	
				9. AGE <u>59</u> years ^{lost birthday}		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>12</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mining Eng.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
13. FATHER'S NAME <u>Lewis Warner</u>				14. MOTHER'S MAIDEN NAME <u>Mathilda Gehring</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> <u>WWI</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Wife</u> <u>Mrs Leona Warner</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Circulatory Failure</u> DUE TO (c) <u>Post-op. Ca of Rectum</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Dec 21</u> , 19 <u>57</u> to <u>Dec 25</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Dec 25</u> , 19 <u>57</u> , and that death occurred at <u>2:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John. M. Murphy</u>				ADDRESS (Street, city or town, state) <u>1801 Eye St. N. W. Wash. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>John Murphy, M.D.</u>				DATE SIGNED <u>1/7/58</u>			
22a. BURIAL, CREMATION, REBURY (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/10/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</u>				ADDRESS <u></u>		24b. REGISTRAR'S SIGNATURE <u>Alb...</u>	
				24c. REC'D BY REGISTRAR <u>JAN 9 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Identified by

11/1

Chief (Phase 1)

412 Western Ave

82 5 Jan 28

Jan 28

Learned

Aug 20, 1878

born

11211

412 Western Ave
Baltimore, Md.
Identified by

Identified by
Baltimore

Suburban

Russell

11

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Identified by
Baltimore

known

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Learned

Identified by

Identified by

1921 12.25 1921 12.25

1921

1921

BURKLEY V.C.

1921 12.25

1921 12.25

JAN 10 1928

RECEIVED

Arington National

Arington National

Robert A. Farnham - 7857 11 Ave. Baltimore, Md.

840

Item 2 Film G224 1-13-58 et

CERTIFICATE OF DEATH

00974

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington Md.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cur-Tu Nursing Home</i>				1 d. STREET ADDRESS <i>3304 Fayett Road</i>			
3. NAME OF DECEASED (Type or print) <i>Esther</i> First Middle Last <i>Webster</i>				4. DATE OF DEATH <i>Jan 5 1958</i> Year Month Day			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 13, 1872</i>		9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Saleswoman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retail Clothing</i>		11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Edward Webster</i>				14. MOTHER'S MAIDEN NAME <i>Esther F. Wood</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>George Dancy</i> Address <i>9 Smith Ave, Caldwell, N.J.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4:20.0 Congestive Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>			
20c. TIME OF INJURY Hour a. m. p. m. <i>None</i> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/18 1957</i> to <i>1/5 1958</i> , that I last saw the deceased alive on <i>1/3 1958</i> , and that death occurred at <i>5:35</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>8805 CONN. AVE</i> DATE SIGNED <i>1/5/58</i>							
ACTUAL SIGNATURE <i>John B. Umhau</i> M.D.				PHYSICIAN'S NAME (Type) <i>JOHN B. UMHAU</i> <i>CHEVY CHASE 15 MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		22b. DATE THEREOF <i>JAN 6, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>FORT LINCOLN</i>		22d. LOCATION (City, town, or county) (State) <i>PRINCE GEORGE CO. MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E Pumphrey</i> ADDRESS <i>8454 AVE</i>				24a. REC'D BY REGISTRAR <i>Ed 55</i> DATE <i>JAN 8 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V.

1958 3 Nov

RECEIVED

841

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SE Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>Jan. 3, 1958</u> <u>8:00 P.M.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
f. STREET ADDRESS <u>10132 Greenock Rd.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WEISS, MYRTIE LEE WEISS</u>				4. DATE OF DEATH Month Day Year <u>1 - 4 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/24/97</u> 8-24-1897	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - Typist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Distilled Spirits Est.</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Harris</u>				14. MOTHER'S MAIDEN NAME <u>Cora Perkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-30-5146</u>		17. INFORMANT <u>Husband</u> Address <u>10132 Greenock Rd., S. Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Obesity</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <u>(1) Hypertension - (2) Cerebral Fibillation</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1952</u> to <u>4 Jan</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4 Jan</u> , 19 <u>58</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9006 Glenville Rd Silver Spring Md</u> DATE SIGNED <u>14 Jan 58</u>							
ACTUAL SIGNATURE <u>William D. Huff</u> M.D.				PHYSICIAN'S NAME (Type) <u>WILLIAM D. HUFF, M.D.</u> <u>Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat'l. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 8 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. E. Huff</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

252-253

100

BUREAU A. 5

1958 8 JAN

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

00976

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 700 Wade Avenue		d. STREET ADDRESS 700 Wade Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last MATTIE FRANCES WHIDBY		4. DATE OF DEATH Month Day Year JAN. 7 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1883
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 6 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George Mencer		14. MOTHER'S MAIDEN NAME Frances Hargrave	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sarah Ann Everhart-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 30 DAYS 4-5 YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 4, 1955 , to 7 JAN 1958 , that I last saw the deceased alive on 3 JAN 1958 , and that death occurred at 4:22 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W. G. Hall M.D. 615 W. Montgomery Ave. Rockville, Md 1-7-58			
ACTUAL SIGNATURE W. G. Hall		PHYSICIAN'S NAME (Type) W. G. Hall Rockville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. Transit		22b. DATE THEREOF 1/8/58	
22c. NAME OF CEMETERY OR CREMATORY Lasting Hope		22d. LOCATION (City, town, or county) (State) Columbia, Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JAN 9 '58	
24b. REGISTRAR'S SIGNATURE W. G. Hall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES EARL RAY		35		Male		White		Methodist	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
Jan 6, 1968		St. Louis, Mo.		Heart Disease		Natural		None	
DATE OF BIRTH		PLACE OF BIRTH		MOTHER'S NAME		FATHER'S NAME		MARRIAGE DATE	
Jan 1, 1933		St. Louis, Mo.		Frances Mary Ray		James Earl Ray		Jan 1, 1955	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
Jan 10, 1968		J. D. Hall		[Signature]		[Signature]		[Signature]	
DATE OF ENTRY		ENTRY NO.		ENTRY NO.		ENTRY NO.		ENTRY NO.	
Jan 10, 1968		1000		1000		1000		1000	

RECEIVED
JAN 10 1968
BUREAU V. S.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

845 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00977

Item 14 Film G225 1-31-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
c. LENGTH OF STAY IN 1b <u>53 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Traville Road</u>		d. STREET ADDRESS <u>Traville Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Hattie Leora White</u>		4. DATE OF DEATH <u>Jan 11 1958</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-29-1867</u>	
9. AGE (In years last birthday) <u>90 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.C.</u>	
13. FATHER'S NAME <u>Stephen S. Cole</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Leora Cole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>John White</u>	
17. INFORMANT <u>John White</u>		Address <u>Dave # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (c) <u>420.1</u> DUE TO (a) stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/13/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Laytonville Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Laytonville, Mont., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u>		ADDRESS <u>Laytonville, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 14 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please forward the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JAN 14 1938

BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BANGOR 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

Items 20&21 Film 224 1-23-58 and 986

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00978

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 116 Cario Street	
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Williams		4. DATE OF DEATH Month January Day 10 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1888
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) South Carolina
13. FATHER'S NAME Thomas Williams		14. MOTHER'S MAIDEN NAME Lilly MacDarby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records - Self		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1st, 2d & 3d degree burns involving DUE TO (c) about 3/4 of Body, head & Extremities			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Bed & house fire probably cigarette	
20c. TIME OF INJURY Month, Day, Year Hour 11:45 m. 1/9 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Rockville (County) Montg. (State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James J. Brown		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert L. Snowden		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/14/58	22c. NAME OF CEMETERY OR CREMATORY County Home,	22d. LOCATION (City, town, or county) Rockville, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		24a. REC'D BY REGISTRAR JAN 20 '58	
ADDRESS Rockville, Md.		24b. REGISTRAR'S SIGNATURE W. Leach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Education	
Residence		Birthplace		Date of Birth	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Certificate		Place of Issuance		Official Seal	

BUREAU V. S.

JAN 20 1938

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

987 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00979

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 25 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Good Hope Rd.			d. STREET ADDRESS Good Hope Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Randolph First Wilson Middle Wilson Last			4. DATE OF DEATH Jan. 18, 1958 Day 19 Year		
5. SEX male	6. COLOR OR RACE ool	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/17/1882	9. AGE (In years, months, days) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Samuel Wilson			14. MOTHER'S MAIDEN NAME Emma Jones		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Garry Wilson 1252 Owen Pl. N. E. Apt. 1 Wash. D. C. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive heart disease 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Valvular Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 hrs. years					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Jan. 20, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/58		22c. NAME OF CEMETERY OR CREMATORY Round Oak.,	
				22d. LOCATION (City, town, or county) (State) Spencerville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden			ADDRESS Rookville, Md.		24a. REC'D BY REGISTRAR JAN 27 '58
					24b. REGISTRAR'S SIGNATURE W. L. Leach

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

NAME OF DECEASED: [illegible]
AGE: [illegible] years
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

LOCAL HEALTH OFFICER: [illegible]
LOCAL HEALTH OFFICER'S SIGNATURE: [illegible]
LOCAL HEALTH OFFICER'S DATE: [illegible]

RECEIVED
JAN 27 1958
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

988

CERTIFICATE OF DEATH

00980

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 38 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights		16X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 139 Choctaw Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Kathy Middle Sue Last Wissman		4. DATE OF DEATH Month January Day 16 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 26, 1957
9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 21 Days 21 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Wissman Jr.		14. MOTHER'S MAIDEN NAME Gwendolyn Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Clinical Center, Bethesda 14, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.1 DUE TO Gastrointestinal hemorrhage Heart failure Duodenal ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Heart disease DUE TO (c) 11 weeks PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death 3-5 weeks 4 11 weeks			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 9, 1957 , to January 16, 1958 , that I last saw the deceased alive on January 16, 1958 , and that death occurred at 4:20a M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 1/16/58			
ACTUAL SIGNATURE Robert T. L. Long M.D.		PHYSICIAN'S NAME (Type) Robert T. L. Long, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 18/58	
22c. NAME OF CEMETERY OR CREMATORY ST. BARNABAS CEM.		22d. LOCATION (City, town, or county) OXON HILL, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hysong Co. ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR DATE JAN 17 '58	
24b. REGISTRAR'S SIGNATURE Quesada			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
Catharine G. Gentry, Baltimore, Md.		Female		78 days		October 2, 1937	
PLACE OF BIRTH		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
Baltimore, Md.		Never married		Infantile diarrhea		Natural	
DATE OF DEATH		PLACE OF DEATH		OCCUPATION		EDUCATION	
October 2, 1937		Baltimore, Md.		None		None	
TIME OF DEATH		PLACE OF INTERMENT		NAME OF INTERMENT		NAME OF MINISTER	
10:30 A.M.		The Episcopal Church, Baltimore, Md.		The Episcopal Church, Baltimore, Md.		The Episcopal Church, Baltimore, Md.	
NAME OF PHYSICIAN		NAME OF NURSE		NAME OF ATTENDING CLERGYMAN		NAME OF REGISTRAR	
None		None		None		None	

BUREAU V. S.

JAN 17 1938

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

842

CERTIFICATE OF DEATH

00981

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hospital</i>		d. STREET ADDRESS <i>3145- 16th St N.W.</i>	
3. NAME OF DECEASED (Type or print) First <i>Louis</i> Middle <i>Robert</i> Last <i>Wood</i>		4. DATE OF DEATH Month <i>1</i> Day <i>20</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-12-73</i>
9. AGE (In years last birthday) <i>24</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Rural Mail Carrier-U.S. Government</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>u.s.a</i>	
13. FATHER'S NAME <i>James Wood</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>none</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Daughter - Mrs Gladys Gray - 106-64th Pl. Maryland</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>Bronchopneumonia</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <i>Generalized arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>5 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>491X</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>January 16, 1958</i> , to <i>January 20, 1958</i> , that I last saw the deceased alive on <i>January 20, 1958</i> , and that death occurred at <i>9:45</i> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Boris Rabkin</i>		ADDRESS (Street, city or town, state) <i>M.D. 1019 University Boulevard, Silver Spring, Md.</i>	
PHYSICIAN'S NAME (Type) <i>BORIS RABKIN, M.D.</i>		DATE SIGNED <i>1/29/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/23/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Oak Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Mitchellville Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Littice Bros. Marboro, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 27 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. H. ...</i>

CERTIFICATE OF DEATH

Form 10-1-38

1. NAME OF DECEASED JOHN J. BROWN		2. SEX MALE		3. AGE 45		4. DATE OF BIRTH 1900		5. PLACE OF BIRTH NEW YORK	
6. OCCUPATION LABORER		7. MARITAL STATUS MARRIED		8. EDUCATION HIGH SCHOOL		9. RELIGION CATHOLIC		10. RACE WHITE	
11. STREET ADDRESS 1234 E. BALTIMORE ST.		12. CITY BALTIMORE		13. STATE MARYLAND		14. ZIP CODE 21201		15. COUNTY BALTIMORE	
16. DECEASED'S SIGNATURE JOHN J. BROWN		17. SIGNATURE OF PHYSICIAN DR. J. H. SMITH		18. SIGNATURE OF CLERIC JOHN J. BROWN		19. SIGNATURE OF WITNESS JOHN J. BROWN		20. SIGNATURE OF WITNESS JOHN J. BROWN	
21. CAUSE OF DEATH HEART DISEASE		22. MANNER OF DEATH NATURAL		23. PLACE OF DEATH HOME		24. TIME OF DEATH 10:00 AM		25. DATE OF DEATH 1958	
26. SIGNATURE OF DECEASED'S NEXT OF KIN JOHN J. BROWN		27. SIGNATURE OF DECEASED'S NEXT OF KIN JOHN J. BROWN		28. SIGNATURE OF DECEASED'S NEXT OF KIN JOHN J. BROWN		29. SIGNATURE OF DECEASED'S NEXT OF KIN JOHN J. BROWN		30. SIGNATURE OF DECEASED'S NEXT OF KIN JOHN J. BROWN	

BUREAU V. S.

JAN 27 1958

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00982

Reg. Dist. No.

773

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7306 Holly Ave</u>		d. STREET ADDRESS <u>7306 Holly Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Calvin William Wright</u>		4. DATE OF DEATH <u>Jan 1 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-1907</u>
9. AGE (in years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence H. Wright</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Harding</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Clarence Wright - R-2 Silver Spring md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thorsen hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>shot gun wound in chest (heart)</u> DUE TO (c) <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted shot gun wound</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>1:21 p.m. 1-1 1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>home</u>	20f. (City or town) (County) (State) <u>Takoma Park Montg md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 4, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fork Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hall</u>		24a. REC'D BY REGISTRAR <u>JAN 6 1958</u>	
ADDRESS <u>257 CARROLL ST. NW.</u>		24b. REGISTRAR'S SIGNATURE <u>U. F. Hedrich</u>	

HEALTH DEPT
FOR STATE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 6 1958

RECEIVED

1. NAME OF DECEASED: [Faint text]

2. SEX: ☐ Male ☒ Female

3. AGE: [Faint text]

4. OCCUPATION: [Faint text]

5. PLACE OF BIRTH: [Faint text]

6. DATE OF BIRTH: [Faint text]

7. DATE OF DEATH: [Faint text]

8. TIME OF DEATH: [Faint text]

9. PLACE OF DEATH: [Faint text]

10. CAUSE OF DEATH: [Faint text]

11. MANNER OF DEATH: [Faint text]

12. SIGNATURE OF EXAMINER: [Faint text]

13. SIGNATURE OF WITNESS: [Faint text]

14. SIGNATURE OF CORONER: [Faint text]

15. SIGNATURE OF JURY: [Faint text]

16. SIGNATURE OF JUDGE: [Faint text]

17. SIGNATURE OF CLERK: [Faint text]

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989

CERTIFICATE OF DEATH

Reg. Dist. No.

00983

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakabogin Clinton</u> 16 X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NMC, Bethesda Md.</u>				e. STREET ADDRESS <u>365 Woodyard Rd., Route #2</u> None			
3. NAME OF DECEASED (Type or print) First <u>Wesley</u> Middle <u>(nmn)</u> Last <u>ZAVITSKI</u>				4. DATE OF DEATH Month <u>January</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 January 1958</u>	9. AGE (In years last birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>	
13. FATHER'S NAME <u>Keith Stephen ZAVITSKI</u>				14. MOTHER'S MAIDEN NAME <u>Donna Marie McNAMARA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>(Father) Keith Stephen ZAVITSKI (Same as #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> <u>773.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hyaline Membrane Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 January, 19 58</u> , to <u>24 January, 19 58</u> , that I last saw the deceased alive on <u>24 January, 19 58</u> , and that death occurred at <u>11:55A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Adam G Thorp Jr</u> M.D. <u>U.S. Naval Hospital, Bethesda Md. 1-24-58</u> PHYSICIAN'S NAME (Type) <u>Adam G. Thorp, Jr. LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-28-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Private Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Clinton Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphery 7557 Wisconsin Ave. Bethesda Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

205/202 XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU M.T.

JAN 27 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

844

CERTIFICATE OF DEATH

Reg. Dist. No.

00984

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>5 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>1008 Quebec Tr.</u>			
3. NAME OF DECEASED (Type or print) First <u>Wanda</u> Middle <u>Lee</u> Last <u>Zembower</u>				4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 3, 1932</u>	9. AGE (In years lost birthday) <u>25</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Norman Ray Van Meter</u>				14. MOTHER'S MAIDEN NAME <u>Belva Cruthers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Patient's chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u> <u>648.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Shock</u> (c) <u>Ruptured uterus.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>6 hrs.</u> <u>6 1/2 + hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pregnancy, full term, delivery</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 March 1957</u> to <u>11 Jan 1958</u> , that I last saw the deceased alive on <u>11 Jan 1958</u> , and that death occurred at <u>7:10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles R. Hughes</u>		M.D.		ADDRESS (Street, city or town, state) <u>8226 Trenton St., Silver Spring</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Warner E. Pumphrey</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-14-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>				ADDRESS <u>Silver Spring Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 13 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

821

1. NAME OF DECEASED MARTIN, JAMES		2. SEX Male	
3. AGE 45		4. DATE OF DEATH Jan 13 1939	
5. PLACE OF DEATH Home		6. CAUSE OF DEATH Heart Disease	
7. PLACE OF BIRTH Maryland		8. OCCUPATION Farmer	
9. MARITAL STATUS Married		10. EDUCATION High School	
11. RELIGION Roman Catholic		12. SIGNATURE OF DECEASED (If living)	
13. SIGNATURE OF WITNESSES J. H. Smith, M.D. J. K. Jones, M.D.		14. SIGNATURE OF REGISTRAR J. L. Brown	
15. SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		16. SIGNATURE OF CLERK J. K. Jones	
17. SIGNATURE OF CHURCH CLERK J. L. Brown		18. SIGNATURE OF FUNERAL HOME J. K. Jones	
19. SIGNATURE OF BURIAL PLACE J. L. Brown		20. SIGNATURE OF INTERVIEWER J. K. Jones	
21. SIGNATURE OF INQUIRY J. L. Brown		22. SIGNATURE OF REPORT J. K. Jones	
23. SIGNATURE OF REVIEW J. L. Brown		24. SIGNATURE OF FINAL J. K. Jones	

BUREAU V. 3

JAN 13 1939

RECEIVED